Addendum # 9

Revised Appendix KK

RFP# 305PUR-DHHRFP-BH-MCO-2014-MVA

LOUISIANA BAYOU HEALTH PROGRAM MCO PROPOSAL SUBMISSION AND EVALUATION REQUIREMENTS RFP #	
PROPOSER NAME	UnitedHealthcare Community Plan

THE PROPOSER MUST COMPLETE THIS FORM AND SUBMIT WITH THEIR PROPOSAL.

In responding to this RFP, the Proposer should adhere to the specifications outlined in Section §22 of the RFP. The proposal should address all requirements listed in this appendix and should provide, in sequence, the information and documentation as required.

The Proposer should complete only the first column of this form to provide an index referencing the location of your response to each item listed (page and section number). This completed form should be included as appendix A of your proposal. The DHH Proposal Review Team will review the proposer's response to the RFP as outlined in this evaluation tool. The review team will be comprised of state employees. DHH reserves the right, at its sole discretion, to conduct its own research and/or consult with contracted subject matter experts in order to verify and assess the information presented. **The review, including but not limited to, an assessment of the compliance with specifications and provisions of the RFP, the quality, feasibility, and reasonableness of the proposal, will be the basis for the scoring of the proposal.**

Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items as a part of said Contract (Refer to Section §22 of RFP).

NOTICE: The department reserves the right to conduct its own research and/or consult with contracted subject matter experts in order to verify and assess the information presented.

Page # of Response In Proposal	PART III. ORGANIZATIONAL REQUIREMENTS	Total possible points	Score	DHH Comments
	Section E: Qualifications and Experience	**50**		
1	**E.1** Provide a listing of, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years (including your parent organization, affiliates, and subsidiaries); or If your organization has not had any publicly-funded managed care contracts for Medicaid/CHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years. The listing of contracts should be provided in a table format. For each contract identified, provide each of the following items as a column in the table: the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any.	5		
1	**E.2** Identify whether your organization currently has a Louisiana Medicaid/CHIP managed care contract.	5		

1	**E.3** For any of your organization's contracts listed in response to E.1, has the other contracting party notified the Proposer that it has found your organization to be non-compliant with the terms of your contract? If yes: (1) provide a description of the events concerning the non-compliance, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? Include your organization's parent organization, affiliates, and subsidiaries in this response.	10		
2	**E.4** Identify whether your organization has had any contract listed in response to E.1 terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client; and If the contract was terminated/non-renewed, based on your organization's performance, describe any action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries in this response.	10		

4	**E.5** Provide evidence of current accreditation by national entity – either URAC or NCQA for at least one state product line listed in response to E.1. If you have national accreditation, have you ever had your accreditation status (e.g., NCQA) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Include your organization's parent organization, affiliates, and subsidiaries in this response.	2		
19	**E.6** Provide as an attachment a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item E.1 of this section that had the largest number of enrollees as of January 1, 2014. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization as a result of this review.	3		
19	**E.7** Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries in your response to this question.	5		

20	**E.8** State whether or not your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item C.1 of this part. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses.	5		
20	**E.9** Submit three (3) client references for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix QQ. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps: a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix QQ (for your organization or for subcontractors, adding the following customized information: • Your/Subcontractor's name; • Reference organization's name; and • Reference contact's name, title, telephone number, and email address. b. Send the form to each reference contact along with a new, sealable standard envelope; (continued on next page)	5		

	c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal; d. Instruct the reference contact to: • Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission); • Sign and date it; • Seal it in the provided envelope; • Sign the back of the envelope across the seal; and • Return it directly to you. e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references. Each completed questionnaire should include: • Proposing Organization/Subcontractor's name; • Reference Organization's name; • Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work; • Date reference form was completed; and • Responses to numbered items in RFP Attachment # (as applicable). DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information. **THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.**			

	Section F: Organizational Structure	35		
22	**F.1** Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization's parent organization, affiliates, and subsidiaries that will support this contract.	5		
25	**F.2** Provide an organization chart for this contract (marked as Chart B) including but not limited to positions in 4.2 and 4.3 of the RFP. Indicate what is the FTE for each dedicated to this contract and whether or not the position is located in Louisiana.	10		
29	**F.3** Attach job descriptions (including education and experience qualifications) of employees in key staff positions as defined in Sec. 4.2. Job descriptions should not exceed 2 pages.	10		
29	**F.4** Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than $100,000 annually.	5		
30	**F.5** Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located.	5		

Page # of Response In Proposal	PART IV: Provider Network	Total Possible Points	Score	DHH Comments
	Section G: Network Development	**35**		
39	**G.1** Provide a plan to build a statewide provider network to adequate (Section 7.0) for a membership of 250,000 members that in accordance with the specifications found in Section 7.0 of the RFP and specific efforts to recruit and retain participation quality providers in the Louisiana Medicaid program. Include your process and policies for utilization of out of network providers and your plan to address any gaps in local coverage and maintain adequacy throughout the term of the contract.	20		
63	**G.2** Describe how you will provide tertiary care providers, including trauma centers, burn centers, children's hospital, Level III maternity care; Level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. If you do not have a full range of tertiary care providers describe how the services will be provided including transfer protocols and arrangements with out of network facilities.	5		
65	**G.3** Describe how you will keep all required provider information accurate and current, both internally and the information submitted to DHH for the provider registry.	10		
	Section H: Provider Management	**35**		
69	**H.1** Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.	5		
71	**H.2** Describe your provider grievance and appeal process.	10		

83	**H.3** Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.	5		
84	**H.4** Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled. o Submit sample quality profile reports used by you, or proposed for future use (identify which). o Describe the rationale for selecting the performance measures presented in the sample profile reports. o Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.	10		
87	**H.5** Describe how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers. . Identify the key requirements that will be addressed.	5		

Page # of Response In Proposal	PART V: BENEFITS AND MEMBER MANAGEMENT	Total Possible Points	Score	DHH Comments
	Section I: Member Assessment and Care Coordination	**15**		
95	**I.1** DHH intends to provide MCOs with two years of historic claims data for members enrolled in the MCO effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your MCO effective February 1, 2015. The description should include: • How you will identify these enrollees, and how you will use this information to identify these enrollees, including enrollees who are receiving regular ongoing services; • What additional information you will request from DHH, if any, to assist you in ensuring continuation of services; • How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation; • What information, education, and training you will provide to your providers to ensure continuation of services; and • What information you will provide your members to assist with the transition of care. • Describe your approach to identifying "hot spotters" who are high utilizers and describe any innovative approaches you utilize to be able to identify the difficult to find patients.	5		
113	**I.2** For members who need home health and/or other services upon discharge from an acute care hospital, explain how you will coordinate service planning and delivery among the hospital's discharge planner(s), your case manager(s), your disease management staff member(s), and the home health agency. Further, explain how you will monitor the post-discharge care of enrollees receiving home health services in remote areas.	5		

118	**I.3** Aside from transportation, what specific measures will you take to ensure that members in rural parishes, or other areas where access is an issue, are able to access specialty care? Describe any plans for using telemedicine to expand services. Also address specifically how will you ensure members with disabilities have access?	5		
	Section J: Coordination of Carved Out Services	**20**		
123	**J.1** Describe how you will coordinate with the Louisiana Behavioral Health Partnership (LBHP) State Management Organization (SMO) for the management of shared members, including processes for reciprocal referral for needed services and prescription management (including but not limited to Sections 6.4, 6.34, 6.37 of the RFP). Include how you will engage and educate primary care providers in their role in the provision of basic behavioral services and the coordination of co-existing conditions. Include a description of the role Medical Director for Behavioral Health will play in these efforts.	15		
136	**J.2** Describe how you will coordinate with the Medicaid Dental Benefits Manager for the management of shared members, including processes for reciprocal referral for needed services.	3		
139	**J.3** Describe your approach for coordinating other carved out services including but not limited to Person Care Services, Targeted Case Management and other waiver specific services. Please include a description of how you will identify that your members may be in need of these services and any processes you will have in place for referral to and follow up with the member and provider or payer as appropriate.	2		

	Section K: Case Management	10		
144	**K.1** Describe your approach to MCO case management. In particular, describe the following: • Characteristics of members that you will target for case management services; • How you assess member needs; • How you identify these members; • How you encourage member participation; • What tools you will be using for patient engagement including technology or mobile aps; • How you develop and implement individualized plans of care, including coordination with providers and support services; • How you will get data feeds from hospitals when your member is admitted, discharged or transferred; • How you coordinate your disease management and case management programs; • How you will coordinate your case management services with the PCP; and • How you will incorporate provider input into strategies to influence behavior of members.	5		
172	**K.2** Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid MCO members. Describe how you will leverage existing state and local resources to support health and wellness of your members including but not limited to: • Strategies you will use to work with the Louisiana Office of Public Health to utilize existing capacity in the state for services, outreach or education. Include models you have used in other states that are in partnership or utilize a state's public health infrastructure. (continued on next page)	5		

	• Strategies to utilized faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services			
	Section L: Member Transition	**20**		
185	**L.1** Describe how you will coordinate transition of a member in the following scenarios to minimize member disruption and ensure continuity of care: • From one managed care entity to another (receiving and relinquishing a member); and • Between fee-or-service to/from your MCO. Your processes should address interactions with and processes for engaging existing providers in the transition	10		
199	**L.2** Describe your approach to meeting the newborn enrollment requirements, including how you will: • Encourage Members who are expectant mothers to select an MCO and PCP for their newborns; • Ensure that newborn notification information is submitted, either by you or the hospital, to DHH or its Agent within twenty-four (24) hours of the birth of the newborn; and • Ensure that the birth is properly recorded in the Louisiana Electronic Event Registration System (LEERS).	5		
200	**L.3** Describe the types of interventions you will use prior to seeking to disenroll a Member as described in an MCO-Initiated Member Disenrollment, Section 11 of this RFP. If applicable, provide an example of a case in which you have successfully intervened to avert requesting the disenrollment of a member.	5		

	Section M: Early Periodic Screening, Diagnosis, and Treatment	**10**		
203	**M.1** Describe your system for tracking each member's screening, diagnosis, and treatment including, at a minimum, the components of the system, the key features of each component, the use of technology, and the data sources for populating the system.	5		
205	**M.2** Describe your approach to member education and outreach regarding EPSDT including the use of the tracking system described in M.1 of this part and any innovative/non-traditional mechanisms. Include: • How you will conduct member education and outreach regarding EPSDT including any innovative/non-traditional methods that go beyond the standard methods; • How you will work with members to improve compliance with the periodicity schedule, including how you will motivate parents/members and what steps you will take to identify and reach out to members (or their parents) who have missed screening appointments (highlighting any innovative/non-traditional approaches); and • How you will design and monitor your education and outreach program to ensure compliance with the RFP.	5		

	Section N: Utilization Management	55		
214	**N.1** Provided a detailed description of your utilization management (UM) policies and procedures including but not limited to: • Specific levels and qualifications required for UM staff; • Training you provide your UM staff; • Industry products (Milliman, Interqual, etc.) used and how • Describe any differences between your UM phone line and your member services line with respect to bullets (2) through (7) in item R.1 of this part; • If your UM phone line will handle both Louisiana MCO and non-Louisiana MCO calls, o explain how you will track Louisiana MCO calls separately; and o how you will ensure that applicable DHH timeframes for prior authorization decisions are met.	10		
236	**N.2** Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.	5		
239	**N.3** Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider or a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.	5		

251	**N.4** Describe your plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to DHH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions.	5		
270	**N.5** Discuss approach you will use to address high STI prevalence by incentivizing providers to conduct screening, prevention education, and early detection, including targeted outreach to at risk populations.	5		
273	**N.6** Describe your plan to address prematurity prevention and improved perinatal outcomes. The plan may include but not be limited to the following: • Routine cervical length assessments for pregnant women; • Provision of injectable or vaginal progesterone for every eligible pregnant woman with a history of pre-term labor or a short cervix found in the current pregnancy. • Incentives for vaginal birth after cesarean (VBAC); • Provider or patient incentives for post-partum visit provision within recommended guidelines of 21-56 days post-delivery; • Incentives for use of long acting reversible contraceptives, which are to be provided to the member without prior authorization; and • Interventions to reduce Cesarean section rates including but not limited to prior authorization for induction of labor prior to forty-one (41) weeks gestational age.	10		

286	**N.7** Explain how you will Identify and address underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives and appropriate pain management approaches in patients with sickle cell disease.	5		
291	**N.8** Explain how you will reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than seven years of age.	5		
295	**N.9** Identify how you will assess the quality and appropriateness of care furnished to enrollees with special health care needs.	5		

	Section O: Chronic Care Management Program	20		
304	**O.1** Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for Bayou Health. Include information on work you have conducted in other states, if applicable. Include how you measure success for each of the populations (i.e. 20% reduction in 30-day readmission rate for members with diabetes); any state models you plan to implement in Louisiana; and how you plan to partner with national, state, or community foundations to support this work. Your plan should include but is not limited to: • How recipients will be identified for inclusion into the Chronic Care/Disease Management program, including populations of special interest to Louisiana e.g. reproductive aged women with a history of a prior poor birth outcome and members with Diabetes, HIV, Hepatitis C and sickle cell disease. • How you identify which disease states/ recipient types will be targeted for the Chronic Care/Disease Management program. • How you identify members who require in person case management services. • Plans to integrate with existing resources/programs in Louisiana as well as your plans to have case managers “on the ground” in addition to telephonic case management • How the Chronic Care/Disease Management program will coordinate information and services with the PCP. • Methods for case management in ways other than simply telephone management. These may include the use of pre-existing community organizations, community hubs, community health workers etc. • How you engage patients (in person, mobile apps, telephonic) and explain your model of case management including what types of personnel (lay health workers, nurses, social workers) are providing case management.	20		

	Section P: Non-Emergency Medical Transportation	10		
339	**P.1** Describe in detail your proposed approach to providing non-emergency medical transportation (NEMT) services, including, at a minimum: • What administrative functions, if any, you will subcontract to another entity (If subcontracting this function, the subcontractor information must be provided in response to item F.4); • How you will determine the appropriate mode of transportation (other than fixed route) for a member; • Your proposed approach to covering fixed route transportation; • How you will ensure that pick-up and delivery standards are met by NEMT providers, including training, monitoring, and sanctions; • How you will ensure that vehicles (initially and on an ongoing basis) meet vehicle standards, including inspections and other monitoring; • Your approach to initial and ongoing driver training; • How you will ensure that drivers meet initial and ongoing driver standards; • How your call center will comply with the requirements specific to NEMT calls; and • Your NEMT quality assurance program (excluding vehicle inspection).	10		

	Section Q: Pharmacy	25		
355	**Q.1** Identify your current or proposed PBM, specifying any corporate relationship to the bidder. (If subcontracting this function, the subcontractor information must be provided in response to item F.4)	1		
355	**Q.2** Describe the MCOs flexibility to customize PBM policies and procedures to meet Louisiana specific needs and program goals.	5		
361	**Q.3** Submit a preliminary plan for MCO oversight of the PBM's performance.	5		
363	**Q.4** The drug file for both retail and specialty drugs, including price, must be updated at a minimum every seven (7) calendar days, at the MCO's discretion they may update the file more frequently. Provide a brief summary of your policy, process and frequency for drug file updates.	2		
363	**Q.5** Submit a summary report of three (3) pharmacy utilization management efforts which demonstrated successful outcomes for three (3) separate disease states.	6		
367	**Q.6** Describe at least 2 and no more than 4 existing or proposed educational initiatives the PBM or MCO will take regarding the use of Behavioral Health Medications (including ADD/ADHD), treatment of infectious diseases, and the treatment and control of diabetes ~~and/~~or asthma	6		

	Section R: Customer Service	25		
371	**R.1** Provide a narrative with details regarding your member services line including: o Training of customer service staff (both initial and ongoing); o Process for routing calls to appropriate persons, including escalation; The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity); o Process for handling calls from members with limited English proficiency and persons who are hearing impaired; o Monitoring process for ensuring the quality and accuracy of information provided to members; o Monitoring process for ensuring adherence to performance standards; o How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and o After hours procedures.	10		
387	**R.2** Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2014 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the abandonment rate. Affiliates should be included when determining the largest contract.	5		

387	**R.3** Describe the procedures a Member Services representative will follow to respond to the following situations: o A member has received a bill for payment of covered services from a network provider or out-of-network provider; o A member is unable to reach her PCP after normal business hours; o A Member is having difficulty scheduling an appointment/finding a specialist. o How do you explain to a member why a particular prescription is not covered?	10		
	Section S: Member Grievances and Appeals	**10**		
392	**S.1** Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process, including your approach for meeting the general requirements and plan to: o Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal; o Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and o Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary. Include in the description how data resulting from the grievance system will be used to improve your operational performance.	10		

Page # of Response In Proposal	PART VI: MARKETING & MEMBER MATERIALS	Total Possible Points	Score	DHH Comments
	Section T: Marketing and Member Materials	**30**		
405	**T.1** Describe proposed content for your member educational and marketing materials and attach examples used with Medicaid or CHIP populations in other states. Describe innovative ways that you have engaged in member education. Describe how you will provide equitable marketing throughout the state. Provide examples or descriptions of how your member education and marketing materials will be used to improve service coordination including: o The coordination of carved out and behavioral health services. o Supporting MCO efforts toward EPSDT compliance, appropriate ED utilization, STI education, encouraging the use of prenatal services and prematurity prevention o The use of technological tools, including social media and mobile technology, to engage members. o Partnering with community-based organizations for education and outreach.	20		
427	**T.2** Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated. How will this information be available to members and the public?	2		
429	**T.3** Describe how you will fulfill Internet presence and Web site requirements, as well as any social media components.	3		
432	**T.4** Describe how you will ensure culturally-competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each, including description how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.	5		

Page # of Response In Proposal	PART VII: QUALITY MANAGEMENT	Total Possible Points	Score	DHH Comments
	Section U: Quality Management	**75**		
441	**U.1** Declare whether or not the proposer submitted HEDIS measures in measurement year 2013. Indicate whether the measures were reported for a State Medicaid, CHIP, and/or Commercial product line. Five points will be awarded to proposers with this experience reporting HEDIS measures.	5		
441	**U.2** Complete appendix WW, **HEDIS Scoring Tool** by submitting the Proposer's results for the HEDIS measures specified below for measurement year 2013, for each of your State Medicaid contracts listed in response to E.1. • Adults' Access to Preventive/Ambulatory Health Services • Comprehensive Diabetes Care- HgbA1C component • Chlamydia Screening in Women • Well-Child Visits in the 3,4,5,6 years of life • Adolescent well-Care. • Ambulatory Care - ER utilization • Childhood Immunization status • Breast Cancer Screening • Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents • Follow-Up Care for Children Prescribed ADHD Medication Include the Proposer's legal business name, as defined by L.R.S.12:23, AND the product line name or dba. If the average of seven or more measures for state Medicaid contracts is above the 2013 NCQA HMO National 50th Percentile for Medicaid Product Lines, ten points will be awarded. (continued on next page)	10		

	If the average of all measures for state Medicaid contracts is above the 2013 NCQA HMO National 25th Percentile for Medicaid Product Lines, five points will be awarded. No points will be awarded if all measures do not meet at least the 2013 NCQA HMO National 25th Percentile for Medicaid Product Lines. DHH Reserves the right to independently verify all information provided in Appendix WW.			
442	**U.3** Document experience in other States or previous Louisiana Medicaid managed care experience Describe experience in using results of performance measures, member satisfaction surveys, and other data will be used to drive changes and to positively impact the healthcare status of Medicaid and or CHIP populations.. Provide an example of changes implemented as a result of data collection to improve the health outcomes of your membership in Louisiana or another state Medicaid program. Examples of areas of interest include, but are not limited to the following: • Management of high risk pregnancy • Management of HIV • Sickle cell disease management • Reductions in low birth weight babies • Pediatric Obesity (children under the age of 19) • Reduction of inappropriate utilization of emergent services • Children with special health care needs • Asthma • Diabetes • Cardiovascular diseases • Reduction in racial and ethnic health care disparities to improve health status • Hospital readmissions and avoidable hospitalizations • Reduction in incidence of sexually transmitted infections	20		

457	**U.4** Submit a preliminary description of your Quality Assessment and Performance Improvement Program (QAPI), as described in Section 14.1 of the RFP. Such description should address the following. Proposers may submit information from another state Medicaid program showing proposed adaptations to be made for the Louisiana population. • Proposed membership of the QAPI Committee including roles and responsibilities • Proposed QAPI Work plan including a detailed descriptions of how the QAPI Committee will work with the MCO leadership to monitor quality improvement work, specifically: o performance improvement projects; o medical record audits; o performance measures; o Plan-Do-Study-Act cycles or continuous quality improvement activities; o member and/or provider surveys; and o activities that address health disparities identified through data collection. • Work the QAPI will undergo to improve the health care status of the Louisiana Medicaid population. • Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues. • How the proposer will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner. • How the proposed QAPIs may include, but is not necessarily, limited to the following: o New innovative programs and processes. o Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics or other non-traditional health care settings.	20		

478	**U.5** Describe the process that will be utilized to develop the performance improvement projects (PIPs) identified in Appendix DD of the RFP. Include a preliminary plan for at least one (1) required PIP including the following: • The study question; • he study population; • The quantifiable measures to be used; • Baseline methodology; • Data sources; • Data collection methodology and plan; • Data collection plan and cycle;	20		

Page # of Response In Proposal	PART VIII: PROGRAM INTEGRITY	Total Possible Points	Score	DHH Comments
	Section V: Program Integrity	**60**		
486	**V.1** Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Include other best practices, you have utilized in other contracts that could be utilized in this contract.	50		
508	**V.2** Provide a description your Corporate Program Integrity Division including the Program Integrity Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart D in your response) involved in compliance along with staff levels of authority.	10		

Page # of Response In Proposal	PART IX: SYSTEMS AND TECHNICAL REQUIREMENTS	Total Possible Points	Score	DHH Comments
	Section W: Information Systems	**65**		
511	**W.1** Describe your approach for implementing a management information system in support of this RFP by identifying all information systems (those within and outside your span of control (for claims, clinical and accounting) through which service and utilization data for the La. Medicaid population is processed. Included a Louisiana Medicaid MCO-Program-specific work plan for system readiness and operations that captures: o All Key activities and timeframes, o Projected resource requirements, o Identify the number of dedicated or corporate full-time employees (FTEs) for implementing information systems in support of this contract, and o Provide the work location of the FTE's before, during and after implementation. The work plan should cover activities from ramp up, implementation and ongoing operations.	20		
561	**W.2** Describe results of capability and capacity assessments performed of current systems to ensure they meet or exceed contract requirements. Describe upgrades or enhancements to existing systems needed to meet or exceed contract requirements. Additionally, if no upgrades are anticipated for this project, describe what and when major system changes/enhancements were last made.	10		
566	**W.3** Describe how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. Your description should encompass information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major systems; and continuous testing of all applicable system functions.	10		

577	**W.4** Provide a flow-chart (marked as Chart E) detailing your process for identifying, testing and implementing system changes, to include time frames associated with each step.	5		
582	**W.5** Provide a flow-chart (marked as Chart F) detailing your process for receiving, processing and updating member enrollment, to include time frames associated with each step.	5		
583	**W.6** Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates.	10		
593	**W.7** Describe your plans to utilize ICD-10.	5		
	Section X: Claims Management	**35**		
595	**X.1** Describe system capabilities and limitations of all requirements stated in Section 17.8 Encounter Data, and identify areas where change would be necessary based on requirements stated in the Systems Companion Guide. Identify any limitations or disparities to requirements stated in Section 17.2, 17.8, and 17.10. Describe system capabilities and limitations of all requirements stated in Section 17.10 Pharmacy Claims Processing and the NCPDP Guide located in the Systems Companion Guide. If you presently unable to meet a particular requirement contained in Section 17, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.	10		
608	**X.2** Explain in detail your process for ensuring that all claims (paid, denied, adjustments and voids) are submitted to the Fiscal Intermediary timely and accurately.	10		

618	**X.3** Describe your ability to provide and store encounter data in accordance with the requirements of the RFP and the Louisiana Medicaid specific requirements described in the Systems Companion Guide.	5		
621	**X.4** Describe your methodology for ensuring that claims payment accuracy standards will be achieved. At a minimum address the following in your response: • The process for auditing a sample of claims as described in Section 17.5 Sampling of Paid Claims; • Documentation of the results of these audits; and The processes for implementing any necessary corrective actions resulting from the audit.	10		

Page # of Response In Proposal	PART X: ADDED VALUE TO LOUISIANA MEMBERS,PROVIDERS & EMPLOYEES	Total Possible Points	Score	DHH Comments
	Section Y: Value Added to Members	**100**		
626	**Y.1** Provide a listing, description and conditions under which you will offer value added benefits as described in the RFP Section 6.1.3. The proposed monetary value of these benefits will be considered a binding contract deliverable. If for some reason, including but not limited to lack of member participation, the aggregated annual per member per month PMPM proposed is not expended the department reserves the right to require the MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended. For each value-added benefit proposed: o Define and describe the expanded benefit; o Identify the category or group of Members eligible to receive the expanded service if it is a type of service that is not appropriate for all Members; o Note any limitations or restrictions that apply to the expanded benefit o Identify the types of providers responsible for providing the expanded benefit, including any limitations on Provider capacity if applicable. o Propose how and when Providers and Members will be notified about the availability of such expanded benefits; and o Describe how a Member may obtain or access the Value-added Service; • Describe how, you will identify the expanded benefit in administrative data or encounter data. Indicate the PMPM actuarial value of expanded benefits assuming enrollment of 200,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information. (continued on next page)	100		

	The department will work with its contract actuary to independently review any statements of actuarial value. • Include a statement of commitment to provide the expanded benefits for the entire thirty six (36) month term of the initial contract.			

	Section Z: Value Added to Providers	**100**		
652	**Z.1** Provide a listing, description and conditions under which you will offer value added incentives or enhanced payments to providers in accordance with Section 9.8 of the RFP. The proposed monetary value of these incentives and/or enhanced payments will be considered a binding contract deliverable. If for some reason, including but not limited to lack of provider participation or performance, the aggregated annual per member per month PMPM proposed is not expended the department reserves the right to require the MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended. For each value-added incentive proposed: o Define and describe the provider incentives or expanded payments and associated measures of performance; o If not applicable to all providers; identify the category or group of providers eligible to participated in the incentive or receive enhanced payments; o Note any limitations or restrictions that apply to the incentives or enhanced payments; o Describe how and when Providers and Members will be notified about the availability of such expanded benefits; and o Describe how provider input and feedback will be used to realign incentives as appropriate. (continued on next page)	100		

	• Describe how you will identify the associated payments in administrative data or encounter data. • Indicate the PMPM actuarial value of the proposed provider incentives based on an enrollment of 250,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information. The department will work with its contract actuary to independently verify any statements of actuarial value. • Include a statement of commitment to provide the expanded benefits for the entire thirty six (36) month term of the initial contract. **Appendix PP must be submitted as part of the proposal.**			
	Section AA: Value Added to Louisiana Employees	**25**		
668	**AA.1** Describe the workplace wellness program and employee incentives you will have in place for your Louisiana-based employees within 3 months from the effective date of the contract. Include incentives for participation. Program components, and expected results. The proposed annual monetary expenditure for this program and will be considered a binding contract deliverable. If for some reason, including but not limited to lack of employee participation, the proposed annual expenditure is not expended the department reserves the right to require the MCO to provide an alternate employee wellness benefit of equal value and/or may conduct a reconciliation for the amount unexpended. For each value-added incentive proposed: o Define and describe the wellness program/employee incentives and associated measures of performance; o If not applicable to all employees; identify the category or group of employees eligible (continued on next page)	25		

	to participate~~d~~ in the incentive or receive enhanced payments; o Note any limitations or restrictions that apply to the wellness benefits/incentives; o Describe how and when employees will be notified about the availability of such programs/incentives; and o Describe how employee input and feedback will be used to realign incentives as appropriate. • Describe how you will identify the associated payments in administrative data. • Indicate the total annual expenditures proposed for each of the three (3) contract years. Include a statement of commitment to provide these expenditures for this purpose for the entire thirty six (36) month term of the initial contract.			

PARTS III-X TECHNICAL REQUIREMENTS

Part III. Organizational Requirements

Section E: Qualifications and Experience

E.1 Provide a listing of, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years (including your parent organization, affiliates, and subsidiaries); or

If your organization has not had any publicly-funded managed care contracts for Medicaid/CHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years.

The listing of contracts should be provided in a table format. For each contract identified, provide each of the following items as a column in the table: the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. (5 points)

As the state of Louisiana's largest contractor in the Bayou Health program serving the needs of more than 275,000 members, we have been privileged to serve Louisiana Medicaid members enrolled in the State's CCN-S program since 2012. Nationally, in 23 states, we serve more than 4.8 million members who are enrolled in government-sponsored programs for low income and medically needy populations.

Since 2012, we have won multiple competitive Medicaid/CHIP RFPs and re-bids across the United States. Our successes reflect our tireless commitment to the states we serve and our continued competitiveness during this period of health system transformation. Our vast experience with programs similar to the state of Louisiana's Bayou Health program is provided in Attachment E.1_Publicly-Funded Managed Care Contracts Listing.

E.2 Identify whether your organization currently has a Louisiana Medicaid/CHIP managed care contract. (5 points)

Since 2012, we have been privileged to serve Louisiana Medicaid recipients as a CCN-S for the Bayou Health program. Currently, we serve more than 275,000 Louisiana Medicaid members under this contract. The contract number for this program is DHH CF1.

E.3 For any of your organization's contracts listed in response to E.1, has the other contracting party notified the Proposer that it has found your organization to be non-compliant with the terms of your contract? If yes: (1) provide a description of the events concerning the non-compliance, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation?

Include your organization's parent organization, affiliates, and subsidiaries in this response. (10 points)

[redacted]

[redacted]

[redacted]

[redacted]

E.4 Identify whether your organization has had any contract listed in response to E.1 terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client; and

If the contract was terminated/non-renewed, based on your organization's performance, describe any action taken to prevent any future occurrence of the problem leading to the termination/non-renewal.

Include your organization's parent organization, affiliates, and subsidiaries in this response. (10 points)

[redacted]

- [redacted]
- [redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

- [redacted]

[redacted]

E.5 Provide evidence of current accreditation by national entity – either URAC or NCQA for at least one state product line listed in response to E.1.

If you have national accreditation, have you ever had your accreditation status (e.g., NCQA) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation.

Include your organization's parent organization, affiliates, and subsidiaries in this response. (2 points)

Evidence of Current Accreditation

NCQA

We have a long history of strong NCQA accreditation performance. With 170 Medicaid, Medicare and commercial health plans currently accredited by NCQA, we demonstrate our system-wide commitment to meeting these rigorous standards. In compliance with Section 14.4, we will maintain our NCQA health plan accreditation.

NCQA
Measuring quality. Improving health care.
National Committee for Quality Assurance
has awarded
UnitedHealthcare Community Plan of Louisiana
Medicaid HMO
an accreditation status of
ACCREDITED
for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.
HEALTH PLAN NCQA ACCREDITATION ACCREDITED
CHAIR, BOARD OF DIRECTORS
PRESIDENT
CHAIR, REVIEW OVERSIGHT COMMITTEE
July 22, 2014
DATE GRANTED
July 22, 2017
EXPIRATION DATE

UnitedHealthcare of Louisiana achieved NCQA **Accredited** status (Standards Only) for its Medicaid program as a result of our first survey in 2014. This accreditation is valid from July 22, 2014, through July 22, 2017. This was achieved under the New Health Plan option. When a health plan is surveyed under the New Health Plan option, it is scored on standards only and capped at Accredited status until the first reaccreditation three years later. Across the country, our NCQA accreditations presently include four ratings of "Excellent" and 82 "Commendable" ratings – a very strong indicator of our commitment to quality, measurement and accountability. None of our accreditations have ever been suspended or revoked.

We have provided evidence of our current NCQA accreditation as Attachment E.5-1_NCQA Accreditation_Louisiana.

As illustrated in the table below, our Bayou Health plan received outstanding scores for accreditation standards and guidelines for Quality Management and Improvement (100 percent),

Credentialing (100 percent), Member's Rights and Responsibilities (98 percent) and Utilization Management (91 percent).

Bayou Health Contract Requirements	Points Received	Possible Points	0% 20% 40% 60% 80% 100%
Quality Management	19.14	19.14	**100**
Utilization Management	11.43	12.48	**91.62**
Credentialing	9.35	9.35	**100**
Members' Rights Responsibilities	8.93	9.01	**98.08**

URAC

NCQA and URAC standards, and ERISA regulations, serve as guidelines for ensuring that determination timeline requirements are met, that appropriately qualified behavioral health care professionals are involved in making determinations, and that relevant clinical information is gathered in a consistent manner. These standards also serve as guidelines for ensuring that members are informed of the clinical rationale for denials.

Certificate Number: U130018R - 746

urac

Certificate of Full Accreditation

is awarded to
United Behavioral Health
11030 Optum Circle
Eden Prairie, MN 55344

for compliance with
Health Utilization Management Accreditation Program

pursuant to the
Health Utilization Management, Version 7.0

Effective from the Saturday 18th of February of 2014 through the Wednesday 18th of February of 2017

William Vandervennet
Chief Operating Officer

Susan DeMarino
Vice President of Accreditation Services

URAC
ACCREDITED

URAC accreditation is assigned to the organization and address named in this certificate and is not transferable to subcontractors or other affiliated entities not accredited by URAC.

URAC accreditation is subject to the representations contained in the organization's application for accreditation. URAC must be advised of any changes made after the granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of URAC and shall be returned upon request.

Optum Health Behavioral Solutions currently maintains the accreditations for our managed behavioral health care operations from NCQA and URAC. NCQA accreditations are for Care Advocacy Centers (CAC) serving health plan business and each covered CAC must demonstrate compliance with applicable standards to achieve accreditation. URAC accreditation is applicable to all Optum Health Behavioral Solutions CACs.

Optum Health Behavioral Solutions demonstrates compliance with NCQA and URAC accreditation standards by being subject to rigorous audits of policies and staff documentation related to:

- Adverse benefit determinations (denials)
- Enrollee appeals
- Enrollee complaints
- Information Systems
- Marketing and communications
- Personnel files
- Practitioner credentialing and recredentialing
- Privacy and confidentiality
- Quality management and improvement

We have provided evidence of URAC accreditation as attachment E.5-2_United Behavioral Health_URAC Certificate 2014.

Accreditation Status

As an organization, we are committed to market leadership in all things related to quality and compliance and we have made this commitment for all of our business lines including Medicaid, Medicare and commercial health plans.

The process of achieving and maintaining NCQA accreditation provides health plans with an infrastructure of industry-recognized quality standards and an independent evaluation of plan performance against these standards. Our aggressive pursuit of NCQA accreditation demonstrates our focus on and commitment to quality. This rigorous external review of our communication, product and service offerings are a clear signal to our state partners that their members have unobstructed access to quality health care.

NCQA Scoring Methodology

Over the past 10 years**,** NCQA has continued to adjust its scoring methodology in two ways:

- HEDIS/CAHPS performance has moved from 30 percent of the total score to 50 percent
- NCQA implemented a 20 percent reduction in scoring over the past five years.

Previous methods included the addition of five percentage points for each measure. 2014 will be the final year of national rate adjustments with an addition of one percentage point per measure. Medicaid regional adjustments are still included in scoring but vary by region and measure annually per NCQA Benchmarks & Thresholds. Due to this changing methodology, which is applied annually during the refresh, we have seen some health plans accreditation levels move down. This is **due solely to the change in methodology not due to deteriorating performance**.

NCQA scoring is complex and is based upon annually published benchmarks and thresholds and standard requirements for each plan. Points are based upon performance against regional and national benchmarks with the highest percentile used. During the annual reassessment, a plan may, in fact, improve its overall rate, but due to the many factors applied for the NCQA scoring methodology, the health plan's status may drop. This has occurred with several of our plans. Additionally, our statistical analysis of HEDIS trends indicates small fluctuations occur year over year in HEDIS performance as a result of common cause variation in the health system. Subsequently, where a health plan may be near the cusp of an accreditation level, it may see a decline that is not evidence of declining overall quality but a natural fluctuation in the HEDIS or CAHPS rate. Because we have such a long history of accrediting our commercial programs, this fluctuation can be observed in several plans with changes in accreditation status. Finally, when a health plan is surveyed under the New Health Plan option, it is scored on standards only and capped at Accredited status until the first reaccreditation three years later.

Accreditation Tables

The tables below describe our accreditation status by plan type, current status, year awarded, change in status and additional accreditation notes.

- **Table "A"** reflects accreditation status for our **Medicaid** health plans
- **Table "B"** reflects accreditation for our **Medicare** health plans
- **Table "C"** describes accreditation for our **commercial** health plans (non-publicly funded.) We have included information on our commercial plans to demonstrate our organization-wide commitment to quality. We understand that this is not required information in light of bidder's question 125 in Addendum #8

TABLE A - NCQA Accreditation Status – Medicaid Plans				
State and License	**Current Status**	**Status Change (From/To)**	**Year of Status Change**	**Explanation**
Delaware **Unison Health Plan of Delaware**	Commendable	From Accredited to Commendable	2013	New rating as of July 19, 2013
Kansas **UnitedHealthcare of the Midwest**	Interim Health Plan Evaluation			Interim Survey occurred in March 2014
New Jersey **AmeriChoice of New Jersey**	Accredited	From not Accredited to Accredited	2014	First survey scheduled June 2014
Louisiana **UnitedHealthcare of Louisiana**	Accredited	From not Accredited to Accredited	2014	This plan was surveyed under New Health Plan standards and score is capped at Accredited This accreditation is valid from July 22, 2014, through July 22, 2017.
Florida **UnitedHealthcare of Florida**	Commendable	No Change	2013	
Hawaii **UnitedHealthcare Insurance Company**	Accredited	No Change	2013	This plan was surveyed under New Health Plan standards and score is capped at Accredited.
Maryland **UnitedHealthcare of the MidAtlantic**	Accredited	Commendable to Accredited	2013	HEDIS points declined by 4.7 points and CAHPS increased by 0.81 points. This Plan has been accredited for three years, with two years at Commendable.
Michigan **UnitedHealthcare Community Plan**	Commendable	Excellent to Commendable	2013	HEDIS points declined by three points and CAHPS increased by 0.12 points. This Plan has been accredited for six years, with five of those at Excellent and one at Commendable.
Mississippi **UnitedHealthcare Insurance Company (CHIP)**	Accredited	No Change	2013	This plan was surveyed under New Health Plan standards and score is capped at Accredited.

TABLE A - NCQA Accreditation Status – Medicaid Plans				
State and License	**Current Status**	**Status Change (From/To)**	**Year of Status Change**	**Explanation**
Mississippi UnitedHealthcare of Mississippi (CAID)	Accredited	No Change	2013	This plan was surveyed under New Health Plan standards and score is capped at Accredited.
Nebraska UnitedHealthcare of the Midlands	Commendable	Excellent to Commendable	2012	HEDIS points declined by 4.8 points and CAHPS by 1.7 points. This Plan has been accredited for six years, with four of those at Excellent and two at Commendable.
New Mexico UnitedHealthcare of New Mexico	Accredited	No Change	2013	This plan was surveyed under New Health Plan standards and score is capped at Accredited.
New York UnitedHealthcare of New York	Commendable	Excellent to Commendable	2013	Missed Excellent ranking by 0.0358. HEDIS points declined by 0.31 points and CAHPS increased by 0.12 points This Plan has been accredited for two years, with one year at Excellent and one at Commendable.
Ohio UnitedHealthcare Community Plan of Ohio	Accredited	No Change	2013	
Pennsylvania UnitedHealthcare of Pennsylvania	Accredited	Commendable to Accredited	2013	HEDIS points declined by 2.6 points and CAHPS by 0.2 points. This plan has been accredited for three years, with two years at Commendable.
Rhode Island UnitedHealthcare of New England **Eighth in the NCQA Medicaid 2013 Rankings**	Commendable	Excellent to Commendable	2012	HEDIS points declined by 2.3 points and CAHPS by 1.5 points. 2.5 points were regained in 2013 This Plan has been accredited for seven years, with five years at Excellent and two at Commendable.

TABLE A - NCQA Accreditation Status – Medicaid Plans				
State and License	**Current Status**	**Status Change (From/To)**	**Year of Status Change**	**Explanation**
Tennessee UnitedHealthcare Plan of the River Valley	Commendable	Excellent to Commendable	2010	HEDIS points declined by 1.6 points and CAHPS by two points. This Plan has been accredited for seven years, with three years at Excellent and four at Commendable.

TABLE B - NCQA Accreditation Status – Medicare Plans				
State and License	**Current Status**	**Status Change (From/To)**	**Year of Status Change**	**Explanation**
Alabama UnitedHealthcare of Alabama, Inc.	Commendable	No Change	2013	
Arizona PacifiCare of Arizona, Inc.	Commendable	Excellent to Commendable	2012	HEDIS points declined by 3.68 and CAHPS by 1.88.
Arizona UnitedHealthcare of Arizona, Inc.	Commendable	No Change	2013	
Arkansas UnitedHealthcare of Arkansas, Inc. (H0401)	Commendable	No Change	2013	Standards only per NCQA due to low HEDIS. Contract termed 2014.
California UnitedHealthcare of California	Commendable	Excellent to Commendable	2013	Decline in Accreditation rating due to drop in HEDIS/CAHPS scores.
Colorado PacifiCare of Colorado, Inc.	Commendable	Excellent to Commendable	2012	HEDIS points declined by 2.31 and CAHPS by 2.47.
Connecticut Oxford Health Plans (CT), Inc.	Commendable	Excellent to Commendable	2013	Decline in Accreditation rating due to drop in HEDIS/CAHPS scores. Contract termed 12-31-13.
Connecticut Oxford Health Plans (CT), Inc.	Commendable	Excellent to Commendable	2013	Decline in Accreditation rating due to drop in HEDIS/CAHPS scores.
Florida UnitedHealthcare of Florida, Inc.	Commendable	Excellent to Commendable	2012	HEDIS points declined by 1.68 and CAHPS by 4.36.

TABLE B - NCQA Accreditation Status – Medicare Plans				
State and License	**Current Status**	**Status Change (From/To)**	**Year of Status Change**	**Explanation**
Georgia UnitedHealthcare of Georgia, Inc.	Commendable	No Change	2013	
Oregon/Washington UnitedHealthcare Insurance Company	Commendable	No Change	2013	
Idaho UnitedHealthcare Insurance Company	Commendable	No Change	2013	
Indiana UnitedHealthcare Insurance Company	Commendable	No Change	2013	
Kansas UnitedHealth Care Insurance Company	Commendable	No Change	2013	SNP Only as of 1-1-13
Massachusetts UnitedHealthcare Insurance Company	Commendable	No Change	2013	
Maine UnitedHealthcare Insurance Company	Commendable	Excellent to Commendable	2013	Decline in Accreditation rating due to drop in HEDIS/CAHPS scores.
Illinois/Missouri UnitedHealthcare of the Midwest, Inc.	Commendable	Excellent to Commendable	2013	HEDIS points declined by 0.23 and CAHPS by 0.39.
Iowa/Nebraska UnitedHealthcare of the Midlands, Inc.	Commendable	Excellent to Commendable	2013	Overall loss of 1.44 points
Iowa/Nebraska UnitedHealthcare Insurance Company	Commendable	Excellent to Commendable	2012	Contract termed 12-31-13
Florida UnitedHealthcare Insurance Company	Excellent	Excellent to Commendable	2012	Decline in score due to drop in HEDIS/CAHPS scores.
Nevada Health Plan of Nevada, Inc.	Commendable	No Change	2013	
New Jersey Oxford Health Plans (NJ), Inc.	Accredited	Commendable to Accredited	2013	HEDIS points declined by 3.48 and CAHPS points increased by 1.11.
New York Oxford Health Plans (NY), Inc.	Commendable	No Change	2013	

TABLE B - NCQA Accreditation Status – Medicare Plans				
State and License	**Current Status**	**Status Change (From/To)**	**Year of Status Change**	**Explanation**
New York UnitedHealthcare Insurance Company of New York	Commendable	No Change	2013	
North Carolina UnitedHealthcare of North Carolina, Inc.	Commendable	No Change	2013	
Kentucky, Ohio UnitedHealthcare of Ohio, Inc.	Commendable	No Change	2013	
Oklahoma UnitedHealthcare of Oklahoma, Inc.	Commendable	No Change	2013	
Oregon UnitedHealthcare of Oregon, Inc.	Commendable	No Change	2013	
Illinois UnitedHealthcare of Insurance Company	Accredited	No Change	2013	
Pennsylvania UnitedHealthcare of Insurance Company	Commendable	No Change	2013	Initial Survey 2013
Rhode Island UnitedHealthcare of New England, Inc.	Excellent	No Change	2013	
Tennessee UnitedHealthcare Plan of the River Valley, Inc.	Commendable	No Change	2013	
Illinois/Iowa Tennessee, Virginia-UnitedHealthcare Plan of the River Valley, Inc.	Commendable	No Change	2013	
Texas UnitedHealthcare Community Plan Of Texas, LLC,	Accredited	Commendable to Accredited	2013	Decline in Accreditation rating due to drop in HEDIS/CAHPS scores.
New Mexico/Texas-UnitedHealthcare Insurance Company	Accredited	Commendable to Accredited	2012	HEDIS points declined by 3.65 and CAHPS by 3.57.
Texas UnitedHealthcare Benefits of Texas, Inc.	Commendable	Excellent to Commendable	2012	HEDIS points decreased by 2.33 and CAHPS by 1.23.
Utah UnitedHealthcare of Utah, Inc.	Commendable	No Change	2013	

TABLE B - NCQA Accreditation Status – Medicare Plans				
State and License	**Current Status**	**Status Change (From/To)**	**Year of Status Change**	**Explanation**
Washington UnitedHealthcare of Washington, Inc.	Commendable	Excellent to Commendable	2012	HEDIS points decreased by 0.98 and CAHPS by 2.53.
Wisconsin UnitedHealthcare of Wisconsin, Inc.	Excellent	No Change	2013	
Hawaii - UnitedHealthcare Insurance Company	Commendable	No Change	2013	
Illinois/Missouri UnitedHealthcare Insurance Company	Commendable	Excellent to Commendable	2012	HEDIS points declined by 1.26 and CAHPS by 1.62.
North Carolina UnitedHealthcare Insurance Company	Excellent	Commendable to Excellent	2013	Increase in Accreditation rating due to improvement in HEDIS/CAHPS scores.
Florida UnitedHealthcare Insurance Company	Commendable	No Change	2013	Initial Survey 2013
Kansas/Missouri UnitedHealthcare Insurance Company	Commendable	No Change	2013	
Virginia UnitedHealthcare Insurance Company	Commendable	No Change	2013	
South Carolina UnitedHealthcare Insurance Company	Commendable	No Change	2013	
Florida UnitedHealthcare of Florida, Inc.	Commendable	Excellent to Commendable	2012	HEDIS points declined by 1.68 and CAHPS by 4.36.
Hawaii UnitedHealthcare Insurance Company	Commendable	No Change	2013	
Florida UnitedHealthcare Insurance Company	Commendable	No Change	2013	
New York UnitedHealthcare Insurance Company of New York	Commendable	No Change	2013	

TABLE B - NCQA Accreditation Status – Medicare Plans				
State and License	**Current Status**	**Status Change (From/To)**	**Year of Status Change**	**Explanation**
Connecticut, Massachusetts, Rhode Island, Vermont UnitedHealthcare Insurance Company	Commendable	No Change	2013	

TABLE C - NCQA Accreditation Status – Commercial Plans			
State and License	**Current Status**	**Status Change (From/To)**	**Year of Status Change**
Alabama UnitedHealthcare Insurance Company/United Healthcare Services, Inc.	Accredited	Commendable to Accredited	2013
Arizona UnitedHealthcare Insurance Company/United Healthcare Services, Inc.	Commendable	Excellent to Commendable	2011
Arizona UnitedHealthcare of Arizona, Inc.	Commendable	Excellent to Commendable	2008 2010
Arkansas UnitedHealthcare Insurance Company/United Healthcare Services, Inc.	Accredited	Commendable to Accredited	2013
California UnitedHealthcare of California	Accredited	Commendable to Accredited	2014
Colorado UnitedHealthcare of Colorado, Inc.	Commendable	Excellent to Commendable	2010
Colorado UnitedHealthcare Insurance Company/United Healthcare Services, Inc.	Commendable	Excellent to Commendable	2012
Connecticut Oxford Health Insurance Company	Commendable	Excellent to Commendable	2012
Connecticut Oxford Health Plans (CT), Inc.	Commendable	Excellent to Commendable	2013
Connecticut UnitedHealthcare Insurance Company/UnitedHealthcare Services Inc.	Commendable	No Change	2012

TABLE C - NCQA Accreditation Status – Commercial Plans			
State and License	**Current Status**	**Status Change (From/To)**	**Year of Status Change**
Delaware **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable to Accredited	2013
District of Columbia **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable to Accredited	2013 2014
District of Columbia, Delaware, Maryland, Virginia, West Virginia **Optimum Choice, Inc.**	Accredited	Excellent to Commendable	2008 2014
Florida **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable to Accredited	2014
Florida **UnitedHealthcare of Florida, Inc.**	Accredited	Excellent to Commendable	2014
Florida **Neighborhood Health Partnership, Inc.**	Commendable	Excellent to Commendable	2008
Georgia **UnitedHealthcare of Georgia, Inc.**	Commendable	Excellent to Commendable	2009
Georgia **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Commendable	No Change	2013
Hawaii **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Commendable	No Change	2013
Iowa **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Commendable	No Change	2013
Idaho **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable to Accredited	2013
Illinois **United Healthcare of Illinois, Inc.**	Accredited	Commendable to Accredited	2014
Illinois **UnitedHealthcare Insurance Company/United Healthcare Services, Inc. of Illinois**	Accredited	Commendable to Accredited	2014

TABLE C - NCQA Accreditation Status – Commercial Plans			
State and License	**Current Status**	**Status Change (From/To)**	**Year of Status Change**
Illinois, Kansas, Missouri UnitedHealthcare of the Midwest, Inc.	Commendable	No Change	2011
Indiana –UnitedHealthcare Insurance Company/United Healthcare Services, Inc.	Accredited	Commendable to Accredited	2013
Kansas UnitedHealthcare Insurance Company/United Healthcare Services, Inc.	Accredited	Commendable to Accredited	2013
Kentucky UnitedHealthcare Insurance Company/United Healthcare Services, Inc.	Accredited	Commendable to Accredited	2014
Louisiana UnitedHealthcare Insurance Company/United Healthcare Services, Inc.	Accredited	Commendable to Accredited	2014
Maryland UnitedHealthcare Insurance Company/United Healthcare Services, Inc.	Commendable	No Change	2013
Maryland UnitedHealthcare of Mid-Atlantic, Inc.	Commendable	Accredited to Commendable	2013
Maryland-MD Individual Practice Association, Inc.	Commendable	Excellent to Commendable	2010
Massachusetts UnitedHealthcare Insurance Company/UnitedHealthcare Services, Inc.	Commendable	No Change	2012
Michigan -UnitedHealthcare Insurance Company/UnitedHealthcare Services, Inc.	Accredited	Commendable to Accredited	2014
MidAtlantic - UnitedHealthcare Insurance Company/UnitedHealthcare Services, Inc.	Accredited	Commendable to Accredited	2014
Mississippi UnitedHealthcare Insurance Company/United Healthcare Services, Inc.	Accredited	Commendable to Accredited	2013

TABLE C - NCQA Accreditation Status – Commercial Plans			
State and License	**Current Status**	**Status Change (From/To)**	**Year of Status Change**
Mississippi **UnitedHealthcare of Mississippi, Inc.**	Accredited	Commendable to Accredited	2012
Missouri **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Commendable	Excellent to Commendable	2013
Montana **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable to Accredited	2013
Nebraska **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable to Accredited	2013 2014
Nevada **Neighborhood Health Partnership, Inc.**	Commendable	Excellent to Commendable	2008
Nevada **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Excellent to Commendable	2007
New Hampshire **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Commendable	No Change	2012
New Jersey **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable	2013 2014
New Jersey **Oxford Health Insurance Company**	Accredited	Commendable to Accredited	2013
New Jersey **Oxford Health Plans (NJ) Inc.**	Accredited	Commendable to Accredited	2013
New Mexico **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable to Accredited	2013
New York **Oxford Health Insurance Company**	Accredited	Commendable to Accredited	2012

TABLE C - NCQA Accreditation Status – Commercial Plans			
State and License	**Current Status**	**Status Change (From/To)**	**Year of Status Change**
New York **UnitedHealthcare Insurance Company of New York/United Healthcare Services, Inc. Of NY, Inc.**	Commendable	Excellent to Commendable	2013
New York **Oxford Health Plans (NY), Inc.**	Commendable	Excellent to Commendable	2010
North Carolina **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Commendable	Excellent to Commendable	2013
Ohio **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable to Accredited	2012 2014
District of Columbia, Delaware, Maryland, Virginia, West Virginia **Optimum Choice, Inc.**	Accredited	Commendable to Accredited	2014
Oklahoma **UnitedHealthcare of Oklahoma, Inc.**	Accredited	Commendable to Accredited	2014
Oklahoma **UnitedHealthcare Insurance Company/UnitedHealthcare Services, Inc.**	Accredited	Commendable to Accredited	2014
Oregon **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable to Accredited	2009 2014
Pennsylvania **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable to Accredited	2013
Rhode Island **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Commendable	Excellent to Commendable	2013
Rhode Island **UnitedHealthcare of New England, Inc.**	Commendable	Excellent to Commendable	2012
Tennessee **UnitedHealthcare Services Company of the River Valley, Inc.**	Commendable	Excellent to Commendable	2011

TABLE C - NCQA Accreditation Status – Commercial Plans			
State and License	**Current Status**	**Status Change (From/To)**	**Year of Status Change**
Tennessee **UnitedHealthcare Plan of the River Valley, Inc.**	Commendable	Excellent to Commendable	2011
South Carolina **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable to Accredited	2013
Tennessee **UnitedHealthcare Insurance Company/UnitedHealthcare Services, Inc.**	Accredited	Commendable to Accredited	2013
Texas **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Commendable	Excellent to Commendable	2013
Texas-UnitedHealthcare Benefits of Texas, Inc.	Accredited	Commendable to Accredited	2014
Utah **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable to Accredited	2013
Utah **UnitedHealthcare of Utah, Inc.**	Commendable	Excellent to Commendable	2008
Virginia **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable to Accredited	2013
Washington **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	Commendable to Accredited	2009 2014
Wisconsin **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Commendable	Excellent to Commendable	2012
Wisconsin **UnitedHealthcare of Wisconsin, Inc.**	Commendable	Excellent to Commendable	2014
Wyoming **UnitedHealthcare Insurance Company/United Healthcare Services, Inc.**	Accredited	No Change	2009

E.6 Provide as an attachment a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item E.1 of this section that had the largest number of enrollees as of January 1, 2014. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization as a result of this review. (3 points)

We have included a copy of the 2013 EQRO report and corrective action plan for New Jersey Medicaid as Attachment E.6_EQRO Report_New Jersey. The overall compliance score for UnitedHealthcare Community Plan of New Jersey was 96 percent. Our New Jersey Medicaid contract represents our largest Medicaid health plan by membership as of January 1, 2014.

E.7 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts.

Include your organization's parent organization, affiliates, and subsidiaries in your response to this question. (5 points)

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

E.8 State whether or not your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item C.1 of this part. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. (5 points)

[redacted]

E.9 Submit three (3) client references for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency.

Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix QQ. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:

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

- Your/Subcontractor's name;
- Reference organization's name; and
- Reference contact's name, title, telephone number, and email address.

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

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

d. Instruct the reference contact to:

- Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);

- Sign and date it;
- Seal it in the provided envelope;
- Sign the back of the envelope across the seal; and
- Return it directly to you.

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

Each completed questionnaire should include:

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

DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information. (5 points)

We have provided three client references for major state Medicaid contracts according to the stated instructions for collecting reference information. Please refer to Attachment E.9_Client References for references from the following clients:

- [redacted]
- [redacted]
- [redacted]

Section F: Organizational Structure

F.1 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization's parent organization, affiliates, and subsidiaries that will support this contract. (5 points)

We are proud to have served Bayou Health members since 2012 with strong, dedicated local leadership and staff. With the expansion in the scope of our responsibilities under this contract, we will increase our local presence by building a larger local team to support clinical and administrative operations supporting our Bayou Health members while continuing to be supported by our national team. Functions that will be primarily located in Louisiana with the implementation of this contract will include leadership and all key staff roles identified in Sections 4.2 and 4.3, plus claims/claims research, provider claim resolution services, clinical program management, grievance and appeals, prior authorization, inpatient utilization management, case management, behavioral health, quality, network management, marketing, community outreach, as well as portions of IT, program integrity and pharmacy operations.

Our member and provider call center, located in Houston, will continue to support Bayou Health members and providers with the same high standards and performance that have been delivered under our CCN-S contract. This strategy ensures that members and providers will continue to have access to our experienced and dedicated staff (many of whom are from Louisiana, relocated after Katrina) and that in the event of natural disasters in Louisiana, will support our members and providers without interruption. This staffing plan ensures that we will maintain at least 50 percent local, Louisiana-based staff. We are committed to a strong local presence and to delivering high-quality services to our members, providers, communities and the Department of Health and Hospitals (DHH).

We agree to comply with each specification and requirement outlined in Section 4, Staff Requirements and Support Services, leveraging and building upon our existing Louisiana staff infrastructure.

Employees and Client Base

UnitedHealthcare Community Plan – Client Base Description

In 2012, UnitedHealthcare began serving Medicaid/CHIP members through the state of Louisiana's Bayou Health CCN-S program. As the State's largest Medicaid managed care provider, we currently serve more than 275,000 Louisiana citizens enrolled in the Bayou Health program. Our offices are located in Metairie and Baton Rouge. We are proposing 620 full-time equivalents (FTEs) for the Bayou Health program; at least 50 percent of whom will be located in Louisiana.

We are proud of our record serving Medicaid members in Louisiana. Led by chief executive officer (CEO) April Golenor, our locally based leadership staff achieved NCQA accreditation in 2014 and received outstanding scores for accreditation standards and guidelines for Quality Management and Improvement (100 percent), Credentialing (100 percent), Member's Rights and Responsibilities (98 percent) and Utilization Management (91 percent). Also in 2013, we fielded our first member satisfaction survey using the CAHPS survey. **UnitedHealthcare scored the highest of all Louisiana Bayou Health plans in overall rating of health plans for both the Adult**

and Child surveys, with an average margin over other contractors of 6.75 percent (adult) and 5.25 percent (child). And finally, we received the highest scores on our recent EQRO audit, and are either fully or substantially compliant in more than 99 percent of the items.

We look forward to building upon our existing experience serving the Bayou Health population and support the State in continuing to operate a successful Medicaid managed care program. We will also leverage the capabilities and tools of our parent organization, UnitedHealth Group, and capitalize on our experience in full-risk models from other UnitedHealthcare markets to bring fortified solutions to the Bayou Health managed care program.

Our Louisiana Footprint

UnitedHealthcare understands the local environment, culture and needs of the citizens of Louisiana, having served Louisianians since 1995 after our acquisitions of MetraHealth and Community Health Network of Louisiana, Inc. The UnitedHealthcare brand resonates with Louisiana citizens as a trusted name in health care. In addition to our Louisiana Medicaid membership, we currently serve 182,000 commercial members and 82,000 Medicare members in the state. With two offices in Louisiana and just under 200 employees who are living in the state supporting multiple lines of business, we cover nearly 540,000 members in Louisiana.

Location of Offices

Metairie Office	Baton Rouge Office
3838 N. Causeway Blvd. Suite 2600 LA035-1000 Metairie, LA 70002	8550 United Plaza Blvd. Two United Plaza Baton Rouge, LA 70809

Map of Office Locations

Corporate Structure – UnitedHealth Group (Chart A)

The organizational structure below portrays our corporate structure and lines of responsibility and authority with our parent organization, UnitedHealth Group, and our affiliates. The following chart is a functional representation of the UnitedHealth Group organization.

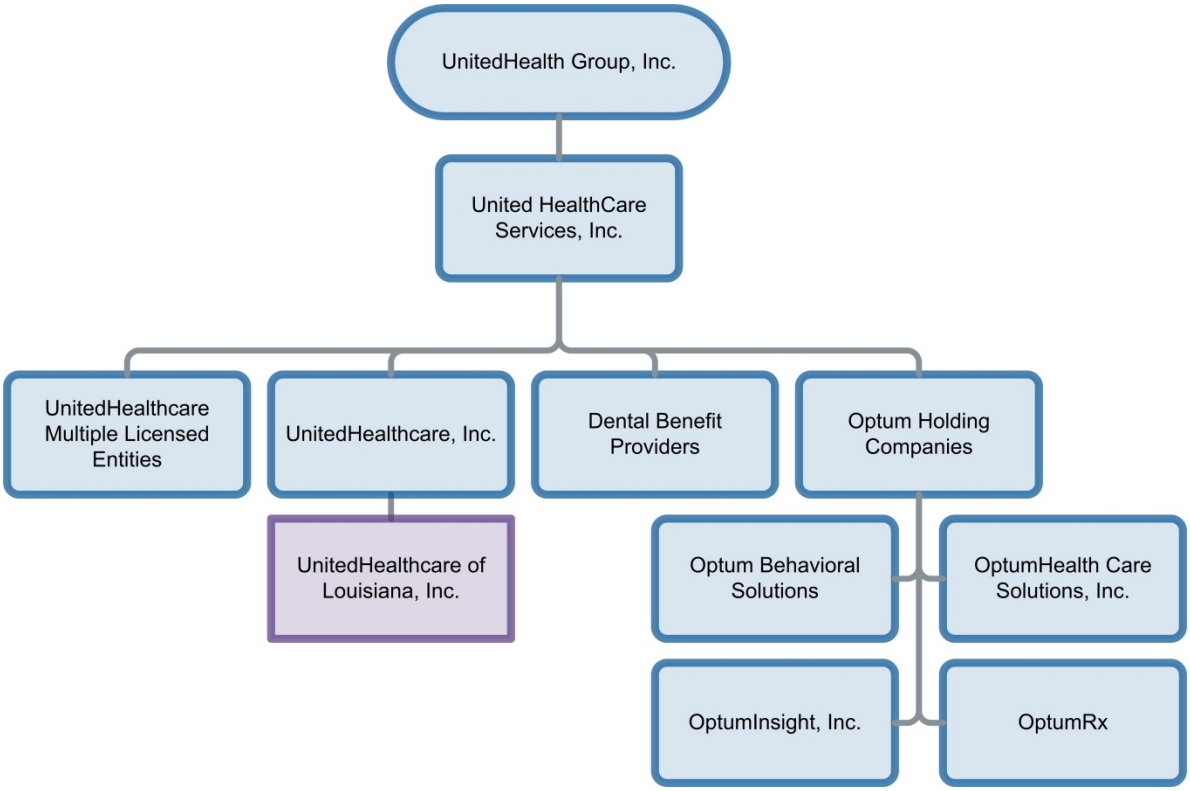

Figure 1. Chart A. Chart A includes UnitedHealthcare's parent organization (UnitedHealth Group), affiliates and subsidiaries that will support this contract.

National Presence and Support

The organizational chart presents the affiliated and/or related business entities (all UnitedHealth Group subsidiaries) that will be providing services on this contract, including:

- ***United HealthCare Services, Inc.*** employs all persons and provides general management and administrative functions to all UnitedHealth Group subsidiaries, including UnitedHealthcare
- ***Dental Benefit Providers*** manages commercial, wholesale and government dental programs across the United States and functions as the legal and administrative entity behind the dental network
- ***Optum Behavioral Solutions*** provides behavioral utilization management and manages the behavioral network
- ***OptumHealth Care Solutions, Inc.*** provides network access and credentialing services for physical therapy and chiropractic providers; provides health and wellness programs and services including case and disease management
- ***OptumInsight, Inc.*** conducts payment integrity functions, including investigation and detection of fraud, waste and abuse; third-party liability; subrogation and provider bill audit; data analytics; consulting; health information systems and data management services
- ***OptumRx*** provides pharmacy benefit management services

UnitedHealthcare and its affiliates currently administer high-quality health care to nearly 540,000 commercial, Medicare and Medicaid Louisiana members. We leverage advanced technology-based transactional capabilities; health care data, knowledge and information; health

care resource organization; and care facilitation to improve access to health and well-being services, simplify the health care experience, promote quality and make health care more affordable. We draw upon our national experience and bring to Louisiana strategies that have proven successful in government programs across the country.

F.2 Provide an organization chart for this contract (marked as Chart B) including but not limited to positions in 4.2 and 4.3 of the RFP. Indicate what is the FTE for each dedicated to this contract and whether or not the position is located in Louisiana. (10 points)

UnitedHealthcare– Local Level (Chart B)

As noted above in F.1 and in accordance with staffing requirements in Sections 4.2, and 4.3, we will dedicate qualified, experienced professionals for the mandatory personnel positions including the required in-state key staff positions as designated in 4.4. This is shown in Chart B below.

Our integrated organizational structure is in place in Louisiana today and meets all contractual requirements identified in the Louisiana Bayou Health CCN-S contract. The organizational structure proposed here illustrates our successful experience managing the Louisiana Medicaid population and leverages our experience in delivering integrated and innovative services to our members, providers and State partners around the country. UnitedHealthcare will support the Louisiana Bayou Health Program at the local level through the staff structure shown below. We are proposing 620 FTEs to manage the Bayou Health program. Of these 620 FTEs, at least 50 percent will be located in Louisiana. Where UnitedHealthcare currently employs a significant number of employees to support our operations under our current program in Louisiana, we will work with DHH through readiness review and implementation to ensure continuity of service through trained staff while adding new staff in Louisiana. We may make adjustments to the number of staff required in different functional areas, and will ensure that we maintain at least 50 percent of total FTEs in Louisiana as noted in Chart B below.

[redacted]

As a current contractor and committed partner to the State, we have gained valuable experience understanding the distinct needs and challenges involved with the care of our Louisiana Bayou Health members. Our local Louisiana leadership team, led by Ms. Golenor, has access to the expertise and resources of one of the nation's leaders in health care services. This allows us to seamlessly support additional growth and respond to the Bayou Health program needs with innovative solutions.

Key Personnel – Mandatory Positions

The following personnel roster lists the names of key staff who will be assigned to perform the duties and services required by this RFP. As required by Section 4.2.1.1, our administrator/chief executive officer and medical director/chief medical officer are dedicated full time to their role.

Position Title	Staff Name	FTE	In state/ Out of State	Job Description Attached
4.2 – Key Staff Positions				
4.2.2 Administrator/Chief Executive Officer (CEO)	April Golenor	1.0	In state 4.4.1	Yes
4.2.3 Medical Director/Chief Medical Officer	Ann Kay Logarbo, M.D.	1.0	In state 4.4.3	Yes
4.2.4 Behavioral Health Medical Director	Charles Freed (interim)	1.0	In state 4.4.4	Yes
4.2.5 Chief Operating Officer (COO)	Karl Lirette	0.5	In state 4.4.2	Yes
4.2.6 Chief Financial Officer (CFO)	Chuck Gleason	1.0	In state	Yes
4.2.7 Program Integrity Officer	Larry Smith	0.5	In state 4.4.5	Yes
4.2.8 Grievance System Manager	Coudra Costict	1.0	In state 4.4.6	Yes
4.2.9 Business Continuity Planning and Emergency Coordinator	Karl Lirette	0.5	In state	Yes
4.2.10 Contract Compliance Coordinator	Larry Smith	0.5	In state 4.4.7	Yes
4.2.11 Quality Management Coordinator	Angela Olden	1.0	In state 4.4.8	Yes
4.2.12 Performance/Quality Improvement Coordinator	Candace Young	1.0	In state	Yes
4.2.13 Maternal Child Health/EPSDT Coordinator	Beverly Shields	1.0	In state 4.4.9	Yes
4.2.14 Medical Management Manager	Linda Rintala	0.5	In state 4.4.10	Yes
4.2.15 Provider Services Manager	Monica Thurmond	1.0	In state 4.4.12	Yes
4.2.16 Member Services Manager	Brad Grundmeyer	1.0	In state 4.4.11	Yes

Position Title	Staff Name	FTE	In state/ Out of State	Job Description Attached
4.2 – Key Staff Positions				
4.2.17 Claims Administrator	Angela Warren	1.0	In state	Yes
4.2.18 Provider Claims Educator	Deborah Tillman	1.0	In state 4.4.13	Yes
4.2.19 Case Management Administrator/Manager	Linda Rintala	0.5	In state	Yes
4.2.20 Information Management and Systems Director	Gabe Moreno (interim, chief information officer)	1.0	In state	Yes
4.2.21 Encounter Data Quality Coordinator	TBD	1.0	In state 4.4.14	Yes
Total		**17**		

Additional Required Staff

4.3 – Additional Required Staff	FTE	In state/Out-of-state
4.3.1 Prior Authorization Staff	21	20 in state/1 out of state
4.3.2 Concurrent Review Staff	50	24 in state/26 out of state
4.3.3 Clerical and Support Staff	24	8 in state/16 out of state
4.3.4 Provider Services Staff	69	16 in state/53 out of state
4.3.5 Member Services Staff	34	0 in state/34 out of state
4.3.6 Claims Processing Staff	129	119 in state/10 out of state
4.3.7 Encounter Processing Staff	5	1 in state/4 out of state
4.3.8 Case Management Staff	63	55 in state/8 out of state
4.3.9 Fraud, Waste and Abuse Investigators & Program Integrity	43	8 in state/35 out of state
Total	**438**	**251 in state/187 out of state**

In addition to required key personnel and additional required staff, we will have the following staff in place for the Bayou Health contract.

Additional Staff	FTE	In state/Out-of-state
Quality Management	14	12 in state/2 out of state
Grievances and Appeals	28	23 in state/5 out of state
Pharmacy Services	60	4 in state/56 out of state
Information Technology	63	5in state/ 58 out of state
Total	**165**	**44 in state/121 out of state**
GRAND TOTAL (Key Personnel, Additional Required Staff, Additional Staff)	**620**	**312 in state/308 out of state**

Proposed Staffing Plan

As noted above, we are committed to a strong local presence and to delivering high-quality services to our members, providers, communities and DHH. We have built this comprehensive staffing plan based on our experience serving Bayou Health members, Louisiana providers,

communities and DHH since 2012 and executing full-risk managed care contracts across the country. We commit to a **minimum of 50 percent of our program staff** for the Bayou Health program in Louisiana by the operational date of February 1, 2015, expanding our current presence in the state. Further, once in place, we will maintain or exceed this level of in state staff for our managed care operations under the new Louisiana Bayou Health contract. Finally, between contract award and the contract effective date, we will deploy additional implementation resources throughout the organization.

F.3 Attach job descriptions (including education and experience qualifications) of employees in key staff positions as defined in Sec. 4.2. Job descriptions should not exceed 2 pages. (10 points)

Job descriptions for key staff positions, as defined in 4.2, are provided in Attachment F.3_Job Descriptions.

F.4 Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than $100,000 annually. (5 points)

Major Subcontractors

UnitedHealthcare acknowledges that we intend to use major subcontractors as defined in the RFP Glossary. In addition to bringing the best of UnitedHealthcare, we chose subcontractors that we are confident will provide the highest quality of care, services and support to our members and meet or exceed all contractual requirements of the Bayou Health program. We are committed to performance-based contracting and close oversight of direct and delegated functions, ensuring Bayou Health members receive all needed care and services.

UnitedHealthcare will subcontract for services from the entities listed below to ensure high quality, comprehensive services for our members. For purposes of this RFP, current subcontractors and proposed subcontractors identified below are considered major subcontractors, with more than $100,000 annually. This list excludes providers.

Affiliate Subcontractors

These major subcontractors listed below are affiliates of UnitedHealth Group:

Subcontractor Name	Mailing Address	Description of Scope/Portions of Work
OptumHealth Care Solutions	6300 Olson Memorial Highway Golden Valley, MN 55427	Provides care management, including NICU and maternity care management, NurseLine and transplant services.
OptumHealth Care Solutions, Physical Health	6300 Olson Memorial Highway Golden Valley, MN 55427	Provides network access and credentialing services for physical therapy, speech therapy and occupational therapy, and chiropractic providers.
OptumRx, Inc.	2300 Main Street Irvine, CA 92614	Provides pharmacy management services.
OptumInsight, Inc.	13625 Technology Dr. Eden Prairie, MN 55344	Conducts payment integrity functions including, investigation and detection of fraud, waste and abuse, as well as data analytics.
Dental Benefit Providers	Liberty 6, Suite 200, 6220 Old Dobbin Lane, Columbia, MD 21045	Provides benefit management services.

Subcontractor Name	Mailing Address	Description of Scope/Portions of Work
United HealthCare Services, Inc.	UnitedHealth Group Center 9900 Bren Road East Minnetonka, MN 55343	Provides services through a Management Services Agreement.

Non-affiliated Subcontractors

These major subcontractors are independent of UnitedHealth Group:

Subcontractor Name	Mailing Address	Description of Scope/Portions of Work
March Vision Care Group, Inc.	6701 Center Drive West, Suite 790 Los Angeles, CA 90045	Manages a network of vision providers and processes vision claims for payment.
Care Core National, LLC	400 Buckwalker Place Boulevard Bluffton, SC 29910	Conducts prior authorization reviews for radiology and cardiology imaging services.
LogistiCare	1275 Peachtree Street NE 6th Floor Atlanta, GA 30309	Manages transportation call center and brokers the transportation services.
Medical Mall Health Services of Louisiana, LLC (which is owned 51 percent by 1st Team Insurance Agency, a LA Hudson initiative certified vendor)	3867 Plaza Tower, 1st Floor Baton Rouge, LA 70816	Provides care transition services through locally based, face-to-face member engagement

F.5 Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located. (5 points)

Monitoring and Evaluating Subcontractors

We are committed to providing the highest quality services to our membership. While the majority of our services are delivered to our members and providers by UnitedHealth Group employees through a management services agreement with our affiliate United HealthCare Services, Inc., we have subcontracted certain services to vendors. For all subcontracted services, we maintain complete accountability and oversight for subcontractors' performance through Ms. Golenor and her local leadership team.

Oversight begins before a subcontractor is selected. We select only subcontractors who support us in improving the effectiveness and efficiency of the delivery of services and have a strong reputation for administrative excellence. In accordance with Health Insurance Portability and Accountability Act (HIPAA), we enter into business associate agreements with all subcontracted partners to ensure compliance with privacy and security regulations. Upon selection of a vendor, a method for reporting and measuring performance, based upon state contractual requirements (including RFP responses) and internal standards is agreed upon with the vendor. In addition, if

the vendor handles member data or has direct connectivity to our systems, we conduct a thorough data security assessment to ensure full integration of these vendors with our own internal systems and processes.

Our national procurement team looks at a minimum of three bids for external vendors, whenever possible. Where appropriate, we strive to include businesses that have been certified by the Louisiana Department of Economic Development under the Louisiana Veteran and Hudson Small Entrepreneurship Initiatives. The selection process also includes a due diligence review of the candidate's past performance and experience, financial strength, innovation, ability to perform the activities to be delegated, and the ability to meet our security standards. When selecting new subcontractors, our vendor management team evaluates each vendor in three categories: quality, accessibility and cost. Following our evaluation process, we select a subcontractor and establish an agreement to govern the operating relationship. This agreement includes delivery of administrative services at a standard to ensure all contract requirements are met.

UnitedHealthcare and its affiliated subcontractors will not enter into a contract with any vendor that has been excluded from participation in a program funded by Medicare or Medicaid, or that has been excluded, sanctioned or debarred from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued by Executive Orders. We monitor and manage the performance of subcontractors through the mechanisms described below. These mechanisms facilitate our oversight of the subcontractors and allow us to evaluate performance, especially with respect to state contractual requirements. Unless otherwise noted, we use these approaches for both external subcontractors and our affiliated entities within UnitedHealth Group.

- ***Operating Arrangements:*** The operating document incorporates a description of the required functions and service levels; the process by which we assess performance; the recourse we have if service standards or expectations are not met (including revocation of delegation or imposing other sanctions if the subcontractor's performance is inadequate); and the authority of Ms. Golenor and the executive team to drive change. Relationships are constructed, formalized and managed with the consent of DHH, the subcontractor and UnitedHealthcare. DHH has the right to review and approve or disapprove all subcontracts for the services provided under this contract. All operating agreements will, at a minimum, conform to the terms and conditions in Section 25 of the RFP.
- ***Sign-off Authority:*** Notifications of any changes to a subcontract that materially affect the subcontract are approved by Ms. Golenor and will be provided to DHH prior to the execution of the change amendment, in accordance with Section 23.1 of this RFP.
- ***Monitoring and Governance:*** We will assign Louisiana executives as Vendor Relationship Owners (VROs) for governance purposes. The VROs will hold regular meetings with our subcontractors at the local and national level. Locally, monitoring activities are conducted regularly by functional area leaders, quality and compliance committees and executive leadership, together with the subcontractors' staff performing the services. This regular governance oversight helps to verify that performance metrics are being met and ensures subcontractors' staff, policies and resources are appropriate to meet the requirements of their agreement. Results of these monitoring activities are reported in functional area committee meetings and compliance committee meetings,

which include our executive leadership. If there are performance issues, these committees recommend next steps of the subcontractor to remedy operational issues and maintain compliance with the contract. This may include a corrective action plan, or if necessary, revocation of the delegation agreement. In addition, we communicate these results and decisions to joint operating committees (JOC), which oversee the intersegment relationships between UnitedHealthcare and its affiliates and vendors, and, as appropriate, our board of directors. Minutes, reviews and any corrective actions from these meetings roll up to our health plan Quality Assurance QAPI committee structure, namely HQUM, SQIS and QMC.

- ***Operations Meetings:*** As appropriate, representatives from our subcontractors are invited to our regular operations meetings, promoting understanding of how each functional area is dependent on the success of the others. During these meetings, we provide direction for our subcontractors and ensure that their quality and effectiveness is sufficient to meet objectives. Local functional area business owners also report on subcontractor performance and measurements. Operations meetings include:
  - Feedback and oversight
  - Review of policies and procedures
  - Training and education
  - Monitoring of key performance indicators
  - Effective lines of communication
  - Responding to issues/escalating when necessary
- ***Performance Oversight Workgroup:*** The Performance Oversight Workgroup acts as an oversight body of UnitedHealthcare, with specific focus on the qualifications and performance of delegated vendors that provide coordination of behavioral health, physical health, dental, vision and NurseLine benefits. The committee consists of the national vendor management team, business and account representatives from vendors and any additional UnitedHealthcare functional members that may be added as necessary. In addition to reviewing the overall relationship between vendors and UnitedHealthcare at a local and national level, the responsibilities of the committee include the following:
  - Review clinical, quality and operational performance metrics of delegated activities against plan-level targets as outlined by established service level agreements. Areas of review include, but are not be limited to, provider network adequacy, claim and call center operations.
  - Discuss any necessary or ongoing corrective action plans, remedial actions or areas for opportunity.
  - Discuss any ongoing, open or significant issues related to member challenges or specific markets.
  - Collaborate on opportunities for new strategic initiatives and new clinical programs that can improve capabilities and consistency in all of our vendors' markets where we have agreements. This includes a review of any programs that have been implemented recently.
  - Output from the committee meetings are documented in written minutes. The Performance Oversight Workgroup will report any identified delegated vendor issues to Ms. Golenor and through our QAPI governance structure. Our corporate oversight

vendor management team will continue to work together with Ms. Golenor and her local leadership team along with the subcontractor through the resolution of any identified issues.

- ***Medicaid Delegate Oversight Committee (MDOC):*** The Performance Oversight Workgroup also reports quarterly to the executive Medicaid Delegate Oversight Committee. The MDOC oversees the development and implementation of an effective and efficient delegate oversight program that meets and exceeds our regulatory and contractual obligations to our key stakeholders. These responsibilities include the primary objective of monitoring the integrity of the procurement processes of UnitedHealthcare, with specific focus on the qualifications and performance of the delegates, the performance of internal contracting procedures, and the compliance with legal and regulatory requirements in the contracting process. The Committee consists of individuals who have responsibilities within in the business, clinical, legal, finance and compliance areas.
- ***Joint Operating Committees (JOC):*** Joint operating committees monitor subcontractor performance at the regional and national level. The scope of the JOCs includes developing compliance strategies and initiatives to support the subcontractor's performance. Included are:
  - Overall review of business performance
  - Assessment of key compliance/regulatory issues and risks
  - Audit planning and reporting
  - Escalation of issues, especially from local health plans
  - Review of fraud, waste and abuse prevention efforts
  - Confirmation of monthly checks of federal and state exclusion lists
  - Response to identified issues

  Membership of the JOCs includes Louisiana plan leadership, national representatives and key business leads from UnitedHealthcare's Community & State (Medicaid) organization and operational partners.

  For clinical operations, the JOC reports issues and trends or risks to the Medicaid Clinical Delegation Oversight Committee (McDOC), composed of senior members of UnitedHealthcare's Community & State. Additionally, the JOCs ensure that there are effective, ongoing response and prevention processes in place. And finally, the JOCs ensure there are open lines of communication as they conduct their oversight activities.

  The JOCs meet on a regular schedule. An expedited meeting may be called to address critical issues in a timely manner as determined by our leadership and our subcontractor(s).
- ***Dedicated Staff:*** We designate accountable relationship owners from the Louisiana health plan in the appropriate functional area to work with specific subcontractors. The local relationship owner works with regional and national relationship owners to perform this oversight. Subcontractors may require additional attention when their responsibilities are of a critical nature or where performance warrants additional oversight. We understand that such steps are necessary for high quality, given the size of our health plan and the large number of members and providers that depend on us. These staff members monitor and drive improvement in our subcontracted services.

- ***Scorecards:*** We also use scorecards during our governance meetings to monitor performance of our vendors against contract requirements. For example, the transportation scorecard below will be modified to meet DHH requirements and will be used during monthly governance calls with our transportation vendor, LogistiCare.

Sample Transportation Scorecard

SAMPLE TRANSPORTATION VENDOR

For each category, a total of 20 points can be earned. See "Status" column below for point scoring key. A total of 10 points can be earned.

Key Measure/ Indicator	Description	Status	Score	Detail and Source Document
Trip Timeliness	At least 30 but no more than 60 mins before appointment, no more than 60 min wait time, confirm 24 hrs before trip, documen trip cancellations, notify member of unavoidable delays	Green - Yes - 20 Points Yellow - In Part - 10 Point Red - No - 0 Points	20	**Measure:** Timeliness reports **Location:**
Call Center Metrics	abandonment rate no greater than 5%, at least 75% of calls answered within 45 seconds,	Green - Yes - 20 Points Yellow - In Part - 10 Point Red - No - 0 Points	20	**Measure:** Call Center Reports **Source:**
Licensure Verification	Verification of new transportation providers, listing of providers terminated, suspended, or restricted	Green - Yes - 20 Points Yellow - In Part - 10 Point Red - No - 0 Points	20	**Measure:** Subcontractor Networking Report **Location:**
Complaints and Grievances	Utilization management and quality management reports; respond to grievances in less than 10 days	Green - Yes - 20 Points Yellow - In Part - 10 Point Red - No - 0 Points	10	**Measure:** Grievance System Reports **Source Document Location:**
Particular issue(s) or concerns		Green - Yes - 20 Points Yellow - In Part - 10 Point Red - No - 0 Points	10	**Measure:** VRO and delegated entity lead identify high risk issues **Source Document Location:**
Total		**out of 100 points**	80	

Scoring Key		Overall Scoring Key	
Green	20 points	Green	80 - 100 points
Yellow	10 points	Yellow	60 - 79 points
Red	0 points	Red	59 points or less

Statistics and Reports: Subcontractors are required to report key performance indicators on a daily, weekly, monthly or quarterly basis. These reports allow UnitedHealthcare staff to monitor and evaluate subcontractors, as well as indicate action steps for improvements. Review of these statistics occurs in monthly and quarterly committee reviews. For example, our maternity case management program, Healthy First Steps, operated by OptumHealth Care Solutions reports monthly on key indicators such as:

- Number of members enrolled
- Number of members reached by case managers
- Members receiving 17P
- Discharges by birth weight
- Percent of total births admitted to NICU

- ***Surveys:*** We perform annual member and provider surveys to gain feedback on the service of subcontractors. Our call center also performs ad hoc surveys if a caller elects to

participate in a survey after their call is completed. Via language-processing software, we analyze text converted from call center conversations to determine member satisfaction levels.

- ***Governance Calls:*** During monthly governance calls, CEO Ms. Golenor, chief operating officer (COO) Karl Lirette and members of the local team meet with executives from our affiliated organizations, allowing for constant exchange of best practices, problem-solving and innovations that are working in other markets. This meeting is attended by executives from our claims operations, member and provider call centers, provider contracting, pharmacy and other functional areas as needed. In addition, this dialogue allows our executive staff to provide direct feedback to our service partners on their service quality and ensure our Medicaid programs are prioritized to promote contract compliance.

UnitedHealthcare uses these overall monitoring approaches and mechanisms to identify and prioritize areas for improvement, set quantifiable goals and metrics, and communicate clear expectations. By creating a systematic approach to evaluate and improve our operations with our subcontractors, we have a process that promotes ongoing identification and remediation of operational challenges and implementation of best practices and innovations.

Subcontractor Services in Other States

Many of our major subcontractors' contract with UnitedHealthcare to perform similar services as required in other states.

Subcontractor Name	Mailing Address	Services provided in other states
United HealthCare Services, Inc.	UnitedHealth Group Center 9900 Bren Road East Minnetonka, MN 55343	Yes. United HealthCare Services, Inc. is the management services company for all UnitedHealth Group companies and provides administrative services on behalf of our Louisiana operations. United HealthCare Services employs approximately 101,763 employees and is an authorized corporation in all states and the District of Columbia. The vast majority of its revenue is derived from providing these services to affiliates and subsidiaries. United HealthCare Services is licensed in Louisiana and many other states across the nation as a third party administrator (TPA) and utilization and medical necessity review agent (UR). United HealthCare Services provides services in the District of Columbia and all 50 states plus several U.S. territories with offices in multiple locations.

Subcontractor Name	Mailing Address	Services provided in other states
OptumInsight, Inc.	13625 Technology Dr. Eden Prairie, MN 55344	Yes. OptumInsight is one of the largest health care information, technology, services and consulting companies in the world. With more than 15,425 employees worldwide, OptumInsight provides technology and services to major participants in the health care industry. Hospitals, physicians, commercial health plans, government agencies, life sciences companies and other organizations that comprise the health care system depend on OptumInsight to help them reduce costs, meet compliance mandates, improve clinical performance and adapt to the changing health system landscape. OptumInsight's products and services are used by more than 125 customers comprised of state, federal and municipal agencies and departments, and nonprofit associations and organizations.
OptumHealth Care Solutions, Inc.	6300 Olson Memorial Highway Golden Valley, MN 55427	Yes. OptumHealth Care Solutions provides services for many programs including Medicaid programs in Arizona, Florida, Hawaii, Iowa, Kansas, Louisiana, Massachusetts, Maryland, Michigan, Mississippi, Nebraska, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Washington and plans for future expansion into other programs. OptumHealth Care Solutions provides personalized health management support and services for more than 30 million Americans through more than 270 state and federal government agencies. These services include holistic wellness and discount programs, customized portal options, decision support, maternity care management, disease management conditions, complex medical condition support, case and utilization management (UM) programs.
OptumRx, Inc.	2300 Main Street Irvine, CA 92614	Yes. OptumRx provides services for many programs including Medicaid programs in: Arizona, Florida, Hawaii, Iowa, Kansas, Massachusetts, Maryland, Michigan, Mississippi, Nevada, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Texas and Washington.
OptumHealth Care Solutions, Physical Health, LLC	9900 Bren Road East Minnetonka, MN 55343	Yes. OptumHealth Care Solutions, Physical Health provides services for many other programs including Medicaid programs in Arizona, Florida, Hawaii, Iowa, Kansas, Massachusetts, Maryland, Michigan, Mississippi, Nebraska, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Washington and Wisconsin and plans for future expansion into other programs. OptumHealth Care Solutions, Physical Health is the chosen subcontractor for accessing therapy services for Bayou Health. OptumHealth Care Solutions, Physical Health offers networks of chiropractors; physical, occupational and speech therapists; and complementary and alternative medicine networks that help manage cost by delivering quality care to members. Currently, OptumHealth Care Solutions, Physical Health serves more than 180,000 members from commercial programs in Louisiana.

Subcontractor Name	Mailing Address	Services provided in other states
Dental Benefit Providers, Inc.	Liberty 6, Suite 200 6220 Old Dobbin Lane Columbia, MD 21405	Yes. Dental Benefit Providers provides services in 50 states for many programs including Medicaid programs in Arizona, Florida, Kansas, Michigan, Mississippi, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Texas, Wisconsin, Serving more than 6 million members nationwide, Dental Benefit Providers' clients include employer groups, health plans, state and local government organizations, insurance companies and TPAs.
March Vision Care Group, Inc.	6701 Center Drive West, Ste. 790 Los Angeles, CA 90045	Yes. March Vision administers benefits for more than 4.9 million members and supports Medicaid programs in the following states: California, Delaware, Florida, Illinois, Maryland, Michigan, Missouri, New Jersey, New Mexico, New York, Ohio, Pennsylvania, South Carolina, Tennessee, Utah, Virginia, Washington, Wisconsin and the District of Columbia. March Vision Care Group is a vision care plan managing and providing vision care programs for health plans, HMOs and the business community. Since 2010, March Vision has been building a Louisiana statewide network composed of ophthalmologists, optometrists and opticians that include family eye doctors and retail chains. In addition to the routine vision benefit, March Vision administers medical vision within the scope of licensure of an optometrist. March Vision assists its health plan partners with outreach activities aimed at diabetic members who have not received their annual eye exam.
CareCore National, LLC	400 Buckwalker Pl Boulevard Bluffton, SC 29910	Yes. With headquarters based in South Carolina and a call-center in Colorado, CareCore National manages utilization management business in all 50 states. CareCore National is an evidence-based health care solutions firm founded in 1994. CareCore National manages utilization management for health care plans for Medicaid, Medicare and commercial populations. CareCore National performs 50,000 plus reviews daily. CareCore provides services for commercial, Medicaid and Medicare members, which includes approximately 320,000 people in Louisiana.

Subcontractor Name	Mailing Address	Services provided in other states
LogistiCare	1275 Peachtree Street NE, 6th Floor Atlanta, GA 30309	Yes. LogistiCare manages 83 non-emergency medical transportation projects in many programs including Medicaid in the following states: Alabama, Arkansas, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Iowa, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maine, Maryland, Michigan, Minnesota, Missouri, Mississippi, North Carolina, Nebraska, Nevada, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Virginia ,Washington, Wisconsin, West Virginia and the District of Columbia. LogistiCare has broad experience with developing and managing transportation subcontractor networks, addressing the needs of geographically dispersed populations, and providing the full array of eligibility and authorization services. Services have been provided in the state of Louisiana since 2012. LogistiCare has been managing non-emergency medical transportation (NEMT) brokerage programs for more than 25 years, and, currently, it ensures NEMT access for over 17 million eligible riders annually and 54 million trips. LogistiCare brings to UnitedHealthcare the experience and successful performance history required to enhance transportation service quality, avoid service disruptions during implementation and manage financial risk.
Medical Mall Health Services of Louisiana, LLC (which is owned 51% by 1st Team Insurance Agency, a LA Hudson initiative certified vendor)	3867 Plaza Tower, 1st Floor Baton Rouge, LA 70816	Yes. Medical Mall provides care transition services through locally based, face-to-face member engagement for our Medicaid program in Mississippi.

Part IV: Provider Network

Section G: Network Development

G.1 Provide a plan to build a statewide provider network to adequate (Section 7.0) for a membership of 250,000 members that in accordance with the specifications found in Section 7.0 of the RFP and specific efforts to recruit and retain participation quality providers in the Louisiana Medicaid program.

Include your process and policies for utilization of out of network providers and your plan to address any gaps in local coverage and maintain adequacy throughout the term of the contract. (20 points)

UnitedHealthcare's primary care provider (PCP) network currently serves the needs of over 275,000 CCN-S Bayou Health members. Our network development plan for a comprehensive managed care network includes a proactive process for recruiting and retaining providers to ensure access for members in all areas of the state – both rural and urban. Our 32 years of experience in building networks in 23 states clearly demonstrates our understanding of the clinical, geographic and cultural needs of our members. Further, we track and trend key network indicators as a way of monitoring our network adequacy and the accuracy of our provider information. **Our high rate of provider satisfaction in Louisiana– an overall satisfaction rating of 84 percent** – demonstrates the value we place on our health care delivery network and drives our network development goals of:

Accuracy
- Use an integrated tracking system to accommodate faster, more accurate provider contracting
- Use both member and provider feedback to update records
- Include contract and claims testing to validate contract configuration

Access
- Respect the cultural diversity of the State and Bayou Health members while meeting access requirements in both rural and urban areas
- Provide additional access through the strength of our commercial network
- Include access to all required services and provider types including Significant Traditional Providers (STPs)

Value
- To members through a comprehensive mix of providers to meet their needs
- To providers through appropriate value-based compensation (VBC) incentives including our Obstetrician Basic Quality Model and Accountable Care Shared Savings Model

Our network development activities are overseen by our locally based provider claims educator Deborah Tillman and provider services manager Monica Thurmond. Together, along with locally based provider advocates, they monitor network activities to maximize our network partnerships and ensure compliance with DHH requirements found in Section 7.0, all state and federal requirements and any other applicable rules or regulations related to the contract including 42 CFR §438.210.(a)(2); 42 CFR §438.206.(b)(4) and (5); and 42 CFR §438.206.(c)(2).

Network Development Plan (7.0)

Our Network Development and Management Plan (Attachment G.1_Network Provider Development Management Plan) is attached and shows how we will maintain full compliance to all requirements outlined in Section 7.0 Provider Network Requirements subsections 7.1 through 7.15; including our specific approach to 7.9 Network Provider Development Management Plan.

It contains a detailed approach for developing, maintaining and monitoring a provider network sufficient to ensure 250,000 Bayou Health members adequate access to all required services included in the contract. Our plan is designed to continually evolve to address the changes in membership, cultures, situations, events, opportunities and concerns. As such, it is reviewed and updated when a significant change occurs to the network and at least annually in accordance with Section 7.9.1.

Throughout this response, we demonstrate our ability to provide a comprehensive network using our proven process for network development, including the following topics:

- Building a Statewide Provider Network
- Recruiting and Retaining Quality Providers
- Policies and Processes for Using Out-of-Network Providers
- Identifying and Addressing Network Gaps in Local Coverage
- Maintaining Network Adequacy

Building a Statewide Provider Network (7.2, 7.3)

Over the past 18 months, UnitedHealthcare has developed and implemented a comprehensive network plan in Louisiana to support the new contract. We will be fully compliant with the access standards described in Sections 7.2 and 7.3 prior to January 1, 2015. We are committed to building a statewide network of health care providers to help DHH achieve the following goals:

- Improve health outcomes for Bayou Health members through a patient-centered medical home (PCMH) delivery system (which we call our Accountable Care Communities)
- Reduce the rate of avoidable hospital stays and ER visits through a greater emphasis on disease prevention and management of chronic conditions
- Achieve cost savings compared to a fee-for-service (FFS) delivery system

A key indicator of our readiness to ensure statewide access to care for Bayou Health members is the strength of our existing contracted network infrastructure currently supporting our CCN-S Medicaid plan and our Louisiana commercial members. For the full-risk Bayou Health contract, we are leveraging our broader commercial network relationships to expand the Medicaid network to include all the provider types needed to ensure adequate access to all required services included in the contract.

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The Importance of a Strong PCP Network

Results for Louisiana UnitedHealthcare ACCs:

Results shown compare CY2013 to Apr. 30, 2014

- Inpatient admission rates show a 15.9% decrease
- Inpatient readmission rate shows 16.1% decrease
- ER admission rate shows 10.3% decrease

Our current Louisiana Medicaid PCP network meets access standards for 100 percent of Bayou Health members enrolled in the CCN-S plan throughout the State. This robust network was initially developed four years ago to support the state's transition to managed care and we have continued to enhance it over the past three years to ensure that we meet and exceed the state's access and adequacy standards and we meet the needs of our Bayou Health members. A strong PCP network is essential for establishing Accountable Care Communities (ACCs – expanded PCMHs) which optimize the use of a PCP as the medical home in a patient-centered service delivery model. We contract with qualifying ACC practices to provide care management and health interventions for high-risk members and their attributed populations. Our ACC program aligns with DHH's goal to reduce the rate of avoidable hospital stays and readmissions and is advancing our efforts to drive member engagement and improve health care quality and outcomes. For members in an ACC, we have already seen double-digit decreases in ER, inpatient hospitalization and readmission rates. The strength of our PCP network positions us well to improve health outcomes for members through ACCs.

Our Proven Network Development Process – Anticipated Membership (7.9.1.1)

Our proven network development process is built upon UnitedHealthcare's 32 years of Medicaid experience and a deep understanding of how to support members and their families by placing them at the center of care and surrounding them with all of the resources and facilities necessary to enable them to successfully participate in improving their health and well-being. Based upon our previous experience building a comprehensive primary care network in Louisiana for the Medicaid CCN-S program, we have a unique understanding of how to recruit and retain the provider types necessary to ensure access to services for 250,000 Bayou Health members.

Our local Louisiana leadership team understands Louisiana and the unique health care needs of Bayou Health members and is committed to providing an exceptional provider network to ensure access to the services they need to live healthier lives. Ms. Golenor, chief executive officer, is responsible for ensuring the adequacy and sustainability of our provider network. Network development and management activities are directed by chief operating officer Mr. Lirette and managed by provider claims educator Ms. Tillman.

Our Louisiana networks are built around providers who value diversity and are committed to serving traditionally underserved populations. The networks will contain adequate numbers of PCPs, hospitals, specialists, tertiary care providers, pharmacies and ancillary providers complemented by a strong network of safety net providers that typically include health departments, federally qualified health centers (FQHCs), rural health clinics (RHCs), school based health centers (SBHCs) and other safety net clinics. Our experience in recruiting, contracting, monitoring, maintaining and credentialing community-based safety net physicians and providers enables us to effectively enhance the member's access to quality care – leading to improved health outcomes with a greater emphasis on disease prevention and management.

Understanding Louisianians (7.9.1.2)

In addition to our Medicaid members, UnitedHealthcare has been serving Louisianians for more than 17 years through our commercial lines of business, making our total health care membership in Louisiana nearly 540,000 members. At the core of our Louisiana presence is an understanding of the member population including their unique health care needs, member diversity and how cultural needs impact the provision of quality health care services and the importance of engaging local providers to serve members. Our network development strategy and plan focuses on delivering services to members in the communities where they live, considering each provider's cultural competence, accessibility to the provider's premises and any special communication abilities as an integral part of our network development.

Knowing Our Members
Our Louisiana-based staff understands that close to **80 percent** of our Medicaid members are children – requiring a network development focus on PCPs and pediatric specialists.

Our experience providing health care and services to more than 275,000 Medicaid members in Louisiana provides us with a clear understanding of the expected utilization patterns for Bayou Health members. We understand there are many health issues and disparities in Louisiana in the areas of low birth weights, adequate prenatal care and in the management of chronic conditions such as diabetes, obesity, high blood pressure and sexually transmitted infections (STIs). Because nearly 80 percent of Louisiana Medicaid members are children, we experience higher utilization in the area of pediatric care and ER visits. According to DHH's website, the average cost of an ER visit is $1,000, much greater than the cost of a visit to a PCP for the same symptoms. Louisiana ranks third in the nation in per capita ER use. Routine visits to members' PCPs can help build relationships between the member and their PCP. To help address disparities and frequent ER usage, we educate and encourage members to use PCPs, urgent care and convenient care clinics and after-hours programs. UnitedHealthcare has also developed new incentive models for contracted PCPs to partner with us on ways to reduce ER utilization. We believe preventive care is essential to mitigating any potential health risks and reducing overall health care costs.

Numbers and Types of Providers (7.3, 7.9.1.3, 7.9.1.4, 7.9.2)

As previously stated, we currently have more than 4,800 providers in our Louisiana Medicaid contracted provider network with approximately 6,500 additional providers in our commercial network to leverage for contracting to ensure network compliance and adequacy. In our current Medicaid network, more than 98 percent of PCPs are accepting new patients. We expect this number to go even higher as we add providers to the Medicaid network. We are confident our provider numbers and diversity will allow us to comply with all requirements of this RFP related to provider network sufficiency. Our GeoAccess reports to be submitted prior to January 1, 2015,

will demonstrate our capacity to provide the covered services to an anticipated 250,000 Bayou Health members.

To ensure the network contains the number and types of providers required to deliver the covered services, our recruiting efforts focus on meeting the needs of Bayou Health members and complying with the defined access and availability standards. We emphasize contracting with the STPs identified by DHH who have experience providing care to Bayou Health members. We also have existing relationships with nearly all of these providers throughout the state through our participation in the Bayou Health CCN-S program and our commercial programs.

In addition to meeting the training and experience requirements necessary to be credentialed as a network provider, many of our practitioners already have significant experience working with a Medicaid-eligible population. We carefully review all providers' experience and qualifications, including education, training, board-certification status, licensure, hospital privileges and malpractice sanction history.

Geographic Location of Providers and Members (7.9.1.5)

UnitedHealthcare has a comprehensive network of providers capable of serving Bayou Health members statewide. We have thoroughly evaluated our network's ability to accommodate Bayou Health members in accordance with DHH-mandated access standards. A complete GeoAccess analysis will be submitted to DHH prior to January 1, 2015, as requested in Addendum 8 Questions & Answers. While our network accessibility statistics look excellent, we have also included non-emergency medical transportation (NEMT) for Bayou Health members as a service to help overcome access and travel issues, particularly for members in rural areas where providers of specific types may be unavailable. We have a strong relationship and a national contract with LogistiCare, our NEMT provider with experience providing needed NEMT services to Medicaid members. LogistiCare is responsible for all necessary NEMT for our members including transportation to services covered within the scope of this RFP as well as all State plan services currently excluded, such as behavioral health and dental services.

Recruiting and Retaining Quality Providers

A source of pride for our network development team is our ability to recruit, retain and support quality providers in a manner that positively impacts health outcomes for our members, simplifies administrative burdens and promotes increased provider satisfaction.

Under the direction of Ms. Tillman, we have developed a robust network and successful recruitment strategy currently serving our Louisiana members. Giving Louisiana Medicaid members the best possible access to high-quality health care is at the core of our network development strategy.

Determining network recruiting needs involves:

- Assessing the estimated number and demographic profile of members served in each parish
- Understanding the health care services required under the State contract
- Complying with access standards and requirements for GeoAccess distance and travel time and provider ratios

- Understanding the special needs of the Louisiana Medicaid members, including their cultural, language, race and ethnicity characteristics

We prioritize engagement with qualified Medicaid providers who promote culturally sensitive environments and embrace the role of the health care provider in minimizing disparities. To enhance our local network, we will also leverage our national contracts to provide key ancillary services, including pharmacy, laboratory, radiology and hemodialysis services as appropriate.

Developing Network Recruitment Plans (7.6)

We use data to analyze and monitor our network to develop a network recruitment plan to guide our network development efforts, emphasizing specific provider types and geographic areas demonstrating the areas where providers are needed. We understand the requirements of provider participation outlined in section 7.6 and the requirement to offer a contract to the Louisiana Department of Public Health (OPH), all small hospitals meeting the definition of in the Rural Hospital Preservation Act, FQHCs, RHCs, family planning clinics and providers, as well as those identified below as STPs. Recruitment and contracting with these STPs has been a major focus of our contracting efforts with successful outcomes. For example, we have finalized a contract with OPH. The broad-spectrum plans are designed and maintained according to the State's requirements, internal assessments and member needs.

The following resources are used to develop the network recruitment plan:

- ***Strenuus Network 360 Tool:*** This network tool provides a competitive analysis of network strength as well as identification of providers targeted for recruitment efforts, allowing us to strategically recruit providers by type, specialty and geography.
- ***Significant Traditional Providers (STPs):*** We identify and pursue contracts with significant traditional Medicaid providers such as community health centers, RHCs and SBHCs to enhance our network and ensure access to members who rely on these critical community-based providers.
- ***Rural Focus:*** For rural areas, we strive to meet all State access requirements. When developing the network in rural areas where there may be a lack of providers, we target the available network within the service area, which may include adjoining states and bordering counties. In addition, we have experience developing telemedicine capabilities for members in traditionally underserved populations, such as those in rural or tribal areas and we believe Louisiana members can benefit from such services.
- ***Urban Focus:*** In urban areas, where the service provider opportunities exceed the market need, we follow core development guidelines and target a balanced percentage of the provider market to maintain effective market coverage and options for member choice.
- ***Cultural Competency:*** We integrate cultural diversity into our provider recruitment efforts in each region, including plans that focus on fulfillment of member needs (e.g., awareness of health disparities, language barriers and patient preferences) to provide members with a responsive provider network.

Carrying Out Recruitment Efforts

Using the network recruitment plan, our network development team has implemented a customized provider recruitment and gap-fill strategy based upon applications of specified work plan elements.

While recruitment is an ongoing effort, we use the information gathered through analysis efforts to guide the process. The network management team meets regularly to ensure recruitment plans are on track. In addition, we will continue to hold frequent meetings with the care management team to identify steps needed to ensure gaps related to access needs beyond minimum access requirements are considered throughout the recruitment process. As always, continuity of care and convenience of members is our first concern.

Strategies for Retaining Providers

We achieved an overall provider satisfaction rating of 84 percent in 2013, an increase of 10 percent over the previous year. Our success in recruiting, retaining and incentivizing providers is a reflection of our reputation in the community as a caring and committed provider; our thought leadership in terms of the innovations we create to support members and providers; and our ability to work within Louisiana as a valued partner within the communities for which we provide health care. We use a combination of tools and technology to create a supportive provider experience by focusing on ease, simplicity and reducing administrative burden.

Simplified Credentialing and Onboarding Process

In 2013, we credentialed an average 97 percent of new providers within 27 days – bringing them into the network much more quickly than the industry-allowed 180 days.

Bringing providers onboard quickly and efficiently is important to establishing our relationship. For example, drawing upon our national experience, we use the Council for Affordable Quality Healthcare's Universal Provider Datasource (CAQH UPD) as our single-source Provider Source Verification application. This results in a simplified credentialing process, minimizing the effort required by providers, and eliminating frustration. CAQH UPD effectively reduces the provider's administrative costs and eliminates the need to complete multiple, redundant forms.

In addition, timely communication and provider-friendly tools and education are essential to helping providers learn about Louisiana Medicaid programs and UnitedHealthcare operations while building a collaborative experience with our providers. We routinely modify our education programs to meet the needs of new providers, new technology and new demands on a provider's time.

We have a dedicated team of provider advocates who live and work in the communities they serve to better serve providers based upon the unique geographic and demographic challenges they face throughout the State. We recognize a practice located in rural Caldwell Parish faces far different challenges than providers practicing in New Orleans. This allows us to focus our efforts to best meet the needs of members in a member-centered and community-inclusive way.

Engaging Our Provider Relations Team

Our experienced, local provider relations team is led by our provider services manager Monica Thurmond. It also includes three full-time provider advocates: Dana Fisher, Melissa Chambers and Tracey Guidroz, all of whom live in Louisiana. With clearly defined territories and provider assignments, the provider advocates spend most of their work time in the field, meeting with key providers to build relationships, answer questions and identify areas for improvement. They visit key primary care sites on a weekly basis and all sites on a regular basis. In addition, chief medical officer Dr. Ann Kay Logarbo visits hospitals and providers serving a high volume of our members. These visits address provider needs, allow a forum for feedback and give us the ability to gauge program

effectiveness in given regions. As we are able to integrate behavioral health into our program offerings, the new behavioral health medical director will also meet with identified quality providers to recruit them into the network.

The provider advocates are also responsible for education and outreach to their assigned providers, and to assist them with claim issues, member complaints, compliance issues as well as training and education. This local presence supports a single point of contact for all providers and a real opportunity for collaboration and innovative programming for members. Since the inception of the Bayou Health program, our provider advocates have reached out telephonically to welcome 100 percent of providers into our PCP network and have conducted more than 12,500 touch points to providers statewide. As we expand our network, the provider advocates will conduct provider orientations through a variety of methods (like face-to-face meetings, webinars and community forums) so that our providers understand contract requirements, plan processes, claim submission and payment processes.

In addition to being a point of contact for all providers, the provider advocate team holds quarterly Joint Operating Committee (JOC) meetings with high-volume providers and members of our health plan (e.g., quality, member outreach and senior leadership) to present regular updates, refresher trainings, address operational issues, discuss HEDIS outcomes, share utilization data and discuss utilization patterns.

Value-Based Contracting as a Network Development Strategy

As part of our overall network strategy, and to promote quality care for all members, we have developed our value-based contracting program for key providers. The goal of this program is to implement a comprehensive portfolio of clinical payment innovations that balance standardization and customization. The program focuses on achieving better health outcomes, increasing patient satisfaction, improving transitions across care settings and reducing health care costs by:

- Improving access to care
- Reducing avoidable hospital admissions
- Reducing inappropriate ER utilization
- Improving care of high-risk members

We are offering value-based contracts to key providers as an incentive to participate in our network.

[redacted]

[redacted]

Technology Enhancements

Supporting our network providers with tools to make administering a program easier allows providers to focus more attention on improving the quality of care for our members is a key component of a successful managed care strategy. We continuously develop technology enhancements to support our network providers and improve our ability to impact the health outcomes for our members. Recent enhancements include the following:

[redacted]

[redacted]

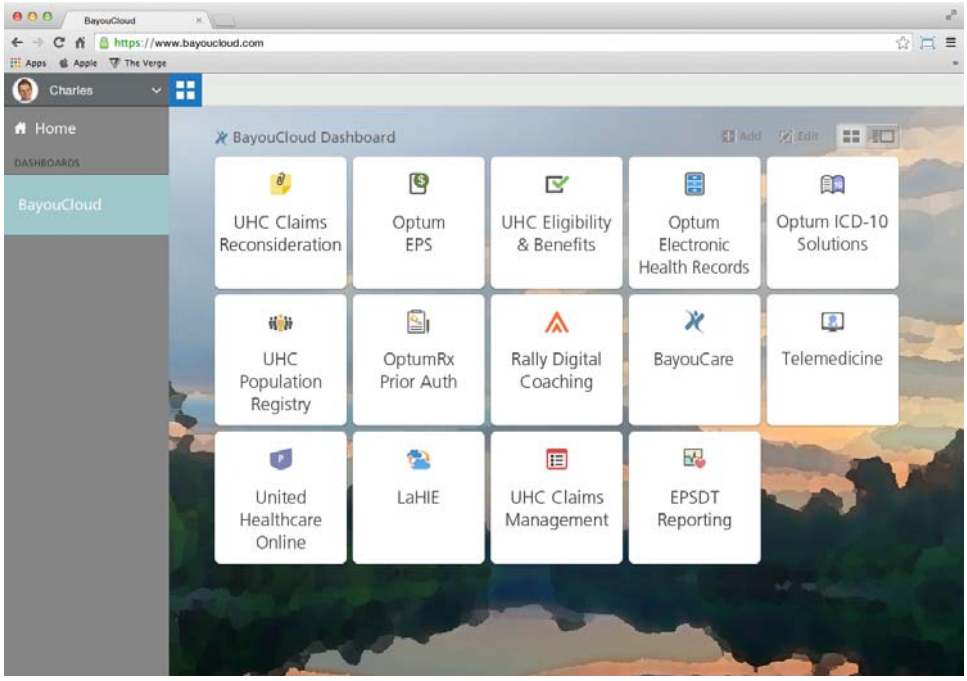
BayouCloud and Administrative Simplification: The primary source of provider information during and after business hours is our secure provider Web portal. The currently available provider portal is being enhanced to allow providers to submit inquiries and receive a response, significantly reducing administrative burden by allowing submission at any convenient time. This functionality will be available by the contract start date of February 1, 2015.

We continue to pursue innovative solutions to streamline and simplify our providers' administrative experiences. Our most recent evolution of online tools is a cloud-based website, which we have private-labeled specifically for our Louisiana providers as BayouCloud. At the foundation of a goal to create a single provider platform, BayouCloud brings together multiple

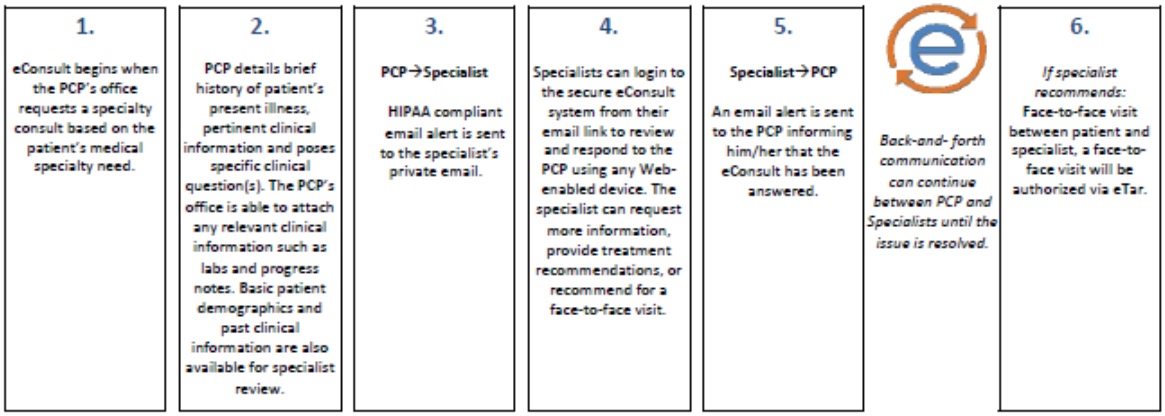
websites, incorporating new applications to improve efficiencies for our providers. With 24 hours a day, seven days a week accessibility, providers use the BayouCloud to conduct business with UnitedHealthcare at any convenient time by logging onto a secure portal with a single sign-on. Our real-time collaborative clinical applications such as eConsult, Population Registry, Automated Care Transition (UHCTransitions), LaHIE Community Health Record and Secure Messaging will all be housed in this portal. Administratively, it will support the following functions:

- ***Claims Reconsiderations:*** Registered users are able to submit claim reconsiderations with attachments — saving time and money by providing seamless submissions with receipt and real-time tracking capability.
- ***Scheduling and Registration:*** Provides greater flexibility for member searches, enhanced benefits search, online submissions of notifications and prior authorizations, document attachments and online inquiry response capabilities – eliminating the need for multiple phone calls.
- ***Claims Management:*** Features include: claims search detail (payment and check information, edits, codes and line level payment); clear claim status remark codes; claim reconsideration link; additional reporting features to assist in account reconciliation; and status indicator for pre and post adjudication claims.
- ***Prior Authorizations***: One of the exciting capabilities of our online technology allows providers to be notified for specific clinical information needed when submitting a procedure for medical necessity review and allows attachment of required clinical information at the time of submissions. It also confirms that clinical information has successfully been attached to the request once the clinical information is uploaded by the provider. And, provides for the ability to track the status of the request as it goes through the various steps of medical necessity review.

The following illustrates the BayouCloud dashboard:



Telemedicine: We have experience developing telemedicine capabilities for members in traditionally underserved populations, such as those in rural parishes. Telemedicine improves access for members, as well as improved health outcomes. For example, our *eConsult* tool enables PCPs to consult remotely and conveniently with specialists to improve health outcomes for members. This tool successfully reduces the need for face-to-face office visits, in medically appropriate cases, by facilitating efficient and secure exchange of health information, and providing increased access to specialty care. We will deploy this subject to approval from DHH.



Policies and Process for Using Out-of-Network Providers (7.1.4, 7.9.2.7)

We recognize our responsibility to provide Bayou Health members with accessible services and providers. When member needs cannot be met by in-network providers, we take immediate steps to address gaps so a member's care is not compromised and continuity of care is assured. Intervention strategies include authorizing needed services with out-of-network providers.

We agree to cover out-of-network services at a cost no greater than if the contracted services were provided by participating providers, for as long as we are unable to provide them. We treat each member's circumstances individually, taking into account linguistic/cultural needs when locating a qualified provider. We establish long-term contracts and incentive programs to improve access and minimize gaps in network accessibility in the following ways:

- ***Short-Term Intervention:*** If a contracted provider is not available to meet member access and availability needs, we arrange for the services to be provided through an out-of-network provider. Out-of-network providers' licensure and Medicaid statuses are validated as they are reimbursed at the State Medicaid reimbursement rate. In the event a provider requires a reimbursement rate higher than Medicaid, we enter into a Single Case Agreement (SCA) which is a binding legal document and requires providers to provide services in compliance with UnitedHealthcare's policies.
- ***Long-Term Intervention:*** We allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member. For example, if a new member previously received services from an out-of-network provider, we continue to authorize services for that provider for continuity of care purposes if it is deemed in the member's best medical interest by our senior clinical leadership including Dr. Logarbo. Providers who meet credentialing requirements can become a participating network provider (e.g., in-network), thereby expanding member convenience and network options for services. Initially, we attempt to contract with the

out-of-network provider and alternatively, work closely with the member and the provider to gradually transition their care to a contracted provider.

- ***Urgent and Emergency Services:*** To mitigate potential delays in accessing urgent or emergency services for circumstances that threaten a member's health or welfare, we do not require prior authorization of these services, regardless of a provider's network status. Members have the right to access emergent or urgent care at any hospital, trauma center, and urgent care or licensed emergency facility. There is no financial or other type of penalty for members who receive care or services from first responders, transportation providers, or from a provider to whom the member was referred through crisis intervention or response service. We provide this information to our members via our *Member Handbook*, new member materials, in-person or telephonic contacts with care coordinators, and peer and family support specialists, telephonic contact to or by member services, and as part of the plan of care development and review process.

Ensuring Appointment Access for Out-of-Network Care

When members' needs cannot be met by network providers, we want to ensure appointment access standards are maintained regardless of the provider's network status. Our care managers provide hands-on assistance in arranging out-of network care as a member's needs dictate. Care manager assistance is tailored to meet member needs, and these appointments are scheduled in compliance with our appointment standards. When care managers contact an out-of-network provider who cannot meet the standards, they continue to outreach until they are able to locate a provider willing to meet the specified access standards. As previously stated, non-network providers operating under an SCA are required to provide care in compliance with our policies, including appointment access standards.

Policies Related to Network Providers (7.9.5, 7.9.7)

UnitedHealthcare maintains network development and management policies and procedures to comply with Section 7.9.5 in accordance with 42 CFR §438.214(a). These policies and procedures outline how we:

- Communicate and negotiate with the network regarding contractual or program changes and requirements.
- Monitor network compliance with policies and rules including compliance with all policies and procedures related to the grievance and appeals process and ensuring a member's care is not compromised during the grievance and appeals process.
- Perform a quarterly comprehensive analysis of our network to maintain compliance with access standards by collecting and analyzing performance indicators, including GeoAccess reports, member complaints and grievances, member and provider satisfaction surveys, provider referral patterns and results of our timely access survey.
- Evaluate the quality of services delivered by the network.
- Provide or arrange for medically necessary covered services when the network becomes temporarily insufficient within a service area.
- Monitor the adequacy, accessibility and availability of our provider network to meet the needs of our members, including providing care to members with limited proficiency in English.

- Process expedited and temporary credentials. Recruit, select, credential, re-credential and contract with providers in a manner that incorporates quality management, utilization, office audits and provider profiling.
- Provide training for our providers and maintain records of the training.
- Track and trend provider inquiries, complaints and requests for information and take system-wide action as necessary and appropriate.
- Acknowledge and resolve provider calls in a timely manner.

In accordance with Section 7.9.7, we will have all of our network development and management policies approved by DHH, Medicaid Managed Care Section and monitored through operational audits.

Identifying and Addressing Network Gaps in Local Coverage (7.5, 7.9.3)

While many factors contribute to overall network adequacy, whether or not members can easily access services is perhaps the most important. Our commitment to accessibility for our members is demonstrated in our existing Louisiana CCN-S PCP network for our Medicaid members, which has 100 percent compliance with the State's distance requirements.

We understand a strong provider network is fundamental to serving the health care needs of Bayou Health members and improving care coordination and health outcomes. Our significant experience serving Medicaid members, caring for underserved populations and providing services to Louisianians and leveraging our commercial network drives our network development efforts. For example, we look for innovative solutions such as engaging all FQHCs and RHCs as part of our strategy, particularly in underserved urban neighborhoods and rural parishes. We have served rural parishes throughout the state for years and have a unique understanding of the distinct needs of both rural providers and members. Further, should DHH decide to carve in a behavioral health benefit, we already have an established, comprehensive network of behavioral health providers throughout the State that includes 896 providers including physicians, social workers, psychologists and registered nurses as well as 203 facilities including inpatient and outpatient facilities, community mental health centers and veteran's administration facilities.

Identifying Network Gaps in Local Coverage (Appendix UU)

A complete managed care network consists of adequate numbers of qualified providers to ensure high-quality health care services for all Bayou Health members within the access and availability standards defined by the State. We continuously measure our network against DHH standards and will be compliant with all standards. At a minimum to ensure members' needs are sufficiently met, we will continue to monitor compliance with the standards through regular compliance reporting as set forth in DHH's Appendix UU – Provider Network – Geographic and Capacity Standards. If we identify network deficiencies, we will work intensively with providers to improve access through extended office hours, use of physician extenders, outreach to non-participating providers using a letter of agreement or identifying specialists for a member consultation. We will also work closely with community providers to help remediate network shortages with

Community Providers as Physician Extenders

We continue to build community partnerships in Louisiana through our Healthify database, a comprehensive compilation of community resources our case managers can tap into to support members.

successful outcomes. For example, we partner with the Louisiana Nurse Family Partnership, which is operated by the Louisiana OPH. Together, we work to improve the health of mothers and infants. In addition, we recognize the role local parish health clinics play in servicing the Medicaid population, including those associated with the Louisiana OPH and OPH-certified SBHCs across the state and value having these clinics in our network. We are contracted with the OPH for all of their health and family planning clinics.

Under the direction of Ms. Tillman, our network operations team currently meet at least monthly to identify potential gaps in our provider network. This interdisciplinary team coordinates an organization-wide response to network development topics such as provider trends, provider profiling, member accessibility issues and provider feedback using the following tools:

- ***Strenuus Network 360 Tool:*** The Network 360 tool provides a competitive analysis of network strength as well as identification of providers targeted for recruitment efforts, allowing us to strategically recruit providers by type, specialty and geography.
- ***Surveys:*** We conduct timely access surveys, PCP-to-member reports, patient satisfaction surveys and feedback from our customer service team. Through careful review of reporting mechanisms, we are able to identify gaps in network access and implement timely corrective measures to ensure proper access for members. We analyze the results and escalate to the appropriate departments for implementation of process improvement. We use annual provider satisfaction and CAHPS member satisfaction survey results to help identify areas for improvement to access to care. We conduct CAHPS surveys at the provider level as well. We also use the quarterly appointment and availability surveys for this purpose.
- ***Physician Profiles:*** We profile our providers and benchmark them across the health plan, utilization outliers (providers with utilization patterns that fall outside the expected range for service delivery). The profile contains preventive care, access to care and utilization management measures. The Provider Advisory Committee (PAC) reviews the outliers and offers assistance to providers to address the issues.
- ***Member and Provider Feedback:*** We monitor member and provider complaints, incidents and inquiries to identify actionable improvements to the network.
- ***Utilization Data:*** We use 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.
- ***GeoAccess Analysis:*** We perform a quarterly analysis of provider availability using GeoAccess software and submit them to DHH as required by Section 7.5.2. Information obtained through the availability analysis is used to manage and monitor the network throughout the year and to focus recruiting efforts.

Addressing Network Gaps in Local Coverage

When we identify gaps, our network operations review team consisting of network management, medical management and quality management, meets to discuss strategies for resolving potential or identified gaps. This interdisciplinary team coordinates an organization-wide response to provider trends, provider profiling, member accessibility issues, member grievances and appeals, and service coordination input reported in the previous month. To address network gaps in local coverage, we work intensively with providers to improve access through extended office hours, use of physician extenders (i.e., physicians' assistants and nurse practitioners), outreach to non-

participating providers using a letter of agreement or identifying specialists for a member consultation. We also look to innovative solutions including the following:

- ***Community providers:*** We work closely with community providers to help remediate network shortages with successful outcomes.
- ***Care extenders:*** In addition to traditional provider recruiting methods we work to improve access to care by identifying and engaging care extenders such as medical assistants, paramedics, pharmacists or telemedicine.
- ***Provider organizations:*** We will also engage provider organizations such as the American College of Emergency Physicians or the Louisiana Academy of Family Physicians to address any network deficiencies.

Leveraging our Medicaid experience serving more than 4.8 million low income and medically fragile members in 23 states and the innovative solutions we have used in other markets, we are able to ensure a provider network fully compliant with contractual requirements. We will continue to report any network deficiencies to DHH quarterly, basing our network analysis upon a comparison between GeoAccess and State standards. In circumstances where network gaps are solely the result of the unavailability of provider types in a parish, we arrange transportation for members to travel to the nearest participating provider. Additionally, in those situations we propose using telemedicine capabilities, when medically appropriate, to address deficiencies. We have considerable experience in the deployment of telemedicine solutions both for physical and behavioral health.

Summary of Current Network Gaps (7.3.1 – 7.3.4, 7.3.6)

A summary of the current network status and any identified gaps by provider type is presented below:

- [redacted]
- [redacted]
- [redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]

Access to Additional Network Providers (7.6.1.1, 7.8.10, 7.8.11, 7.8.13)

In addition to our core network of PCP, hospital and specialist providers, we are committed to providing access to a full range of providers important for the Bayou Health population including FQHCs, RHCs, SBHCs and local parish health clinics.

[redacted]

We will continue to comply with all State requirements set forth in section 7.6.1.1 and 7.8.10 to offer to contracts to all FQHCs and RHCs (both freestanding and hospital-based) in the State.

School Based Health Clinics: Operating as a partnership between a school and a community health organization, SBHCs are an important component of the nation's health care safety net. 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, behavioral health, dental health, substance abuse counseling, nutrition services and health education. Students can be treated for acute illnesses, such as flu, and chronic conditions, including asthma and diabetes. They can also be screened for dental, vision and hearing problems. With an emphasis on prevention, early intervention and risk reduction, SBHCs counsel students on healthy habits and how to prevent injury, violence and other threats. Specific services provided by SBHCs vary based on community needs and resources as determined through collaborations between the community, the school district and the health care providers. Benefits realized by using SBHCs include expanding access to care when and where it is needed and providing a safe place for young members to talk about sensitive issues such as depression, substance abuse and teen pregnancy. SBHCs can also reduce ER visits by providing a place for children to receive health care while parents are at work.

SBHCs
We currently have contracts with 95 percent of the State's school-based health clinics.

Many SBHCs in Louisiana are operated by FQHCs. Our existing FQHC strategy provides strong positioning for developing innovative approaches such as targeted programs designed to further impact health outcomes for school-aged children**.** [redacted]

Local Parish Health Clinics: We recognize the value and role local parish health clinics play in servicing the Medicaid population. We have a contract with the Louisiana OPH for the provision of personal health services such as immunizations, screening and treatment for sexually transmitted disease and family planning offered within parish health clinics. We commit to work with OPH on all public health issues.

Summary of Current Network Development Activities

Following is a summary of how our network development team is addressing potential gaps in service for each provider type:

PCPs: UnitedHealthcare has a very strong presence among PCPs in Louisiana and has longstanding relationships and current contracts with many PCPs through our Medicaid CCN-S program and commercial products. We are presently in contracting discussions with the following physician organizations:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

- [redacted]
- [redacted]

All but one of these physician organizations is already contracted for every product UnitedHealthcare currently has available in Louisiana. Based upon our existing relationships, we are continuing positive discussions with the intent to complete contracts with these providers to provide Medicaid services to Bayou Health members.

We align payment incentives with some of our providers as a means of strengthening provider partnerships and promoting better health outcomes for members. For example, we offer incentive contracts to some high-volume providers who partner in our ACC model using shared incentives, risk pools and additional compensation for improved quality, outcomes and access to care. Our provider incentive strategy is discussed in detail in response to question Z of this proposal.

Hospitals: We monitor, engage and support ongoing network development activities in both urban and rural parishes in Louisiana to ensure high-quality care is available and accessible.

[redacted]

[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

Approximately 20 percent of Louisianians live in rural areas. Typically, the underserved population is higher in these areas, compared to urban areas of the state, and health services including hospitals may not be as readily available. Using the defined DHH access standards, we have already put our network development plan in action, actively negotiation with the following hospital systems within the listed parishes to comply with the rural access standards specified in Section 7.3.2.1.

[redacted]		
[redacted]	[redacted]	[redacted]
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[redacted]	[redacted]	[redacted]
[redacted]		

If no hospital is available within 30 miles of a rural resident, we will ensure the member has access to needed care through a hospital in the nearest parish or an out-of-network provider if necessary.

Ancillary Providers: Ancillary providers support members through the provision of diagnostic or therapeutic services administered through a PCP's or specialist's office, a hospital or a freestanding testing facility. We continue to leverage our national and local commercial contracts to provide key ancillary services, including laboratory, hemodialysis and radiology services as appropriate.

We do not anticipate any network gaps related to access to laboratory and radiology providers. As with other covered services, members can use NEMT to obtain services beyond the distance standards when necessary. Our national relationships and contracts with DaVita and Fresenius help to create a strong hemodialysis network in Louisiana for Medicaid members similar to the network in place for UnitedHealthcare's Louisiana commercial members. We are in active discussion with the additional state-based hemodialysis providers to provide services for Bayou Health members.

Specialists: Specialists are often closely associated with hospitals and large physician organizations. We are in active contracting discussions and expect to have Medicaid contracts with the following physician organizations with high volumes of specialty and subspecialty providers. We expect completing contract negotiations with these providers will ensure member

accessibility to needed specialty services and meet network access requirements. These specialists are already contracted with UnitedHealthcare for our other lines of business and we appreciate the longstanding relationships we've had with them for many years.

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Occasionally, a shortage of specialists occurs in a specific geographic area or statewide for certain specialty types. When a gap exists, we do whatever is necessary to ensure the member gets the needed care. Strategies for ensuring access can include arranging transportation to a network specialist in another parish or a bordering state; using telemedicine capabilities to facilitate access to specialists for Bayou Health members with DHH's prior approval; or using an out-of-network provider when appropriate.

Maintaining Network Adequacy (Appendix UU)

Ms. Tillman is responsible for ensuring the adequacy and sustainability of our provider network by directing network development activities. Our in-depth processes to evaluate and measure the strength, stability and compliance of our Medicaid network have been developed and enhanced over the past 32 years of experience and use proven data sources to evaluate network adequacy. Processes for monitoring network adequacy, managing and improving the network, and sustaining an adequate network are described below.

UnitedHealthcare will meet or exceed network access and adequacy requirements as specified in DHH's Appendix UU – Provider Network – Geographic and Capacity Standards and will maintain a high-quality health care delivery system for Bayou Health members by ensuring all medically necessary covered services are accessible and available through our contracted provider network. As we have done throughout the past 18 months, when we first began building our full-scope network in preparation for this RFP, we will continue to add providers to our network during the period from contract award to contract implementation and through the term of the contract as necessary to ensure access and adequacy for all Bayou Health members.

Monitoring Network Adequacy (7.5)

Our Louisiana network and operations teams will perform comprehensive analysis and develop quarterly GeoAccess reports to maintain compliance with network access standards. By mapping the travel time between the ZIP code of the member's residence and the providers' service locations, we analyze our network of hospitals, primary care and specialty care providers and compare access and availability performance to State requirements. Our Service Quality Improvement Subcommittee (SQIS) monitors network performance, addresses opportunities for improvement and communicates follow-up actions to the Quality Management Committee (QMC). Mr. Lirette chairs the SQIS whose access and availability activities include:

- Review network performance against access standards
- Develop recommendations to address geographic and clinical needs for network expansion
- Monitor, evaluate and implement improvement plans for access and availability of network practitioners, including evaluating member satisfaction data
- Monitor the linguistic competencies of provider offices compared with languages spoken by members and providing access to interpretive services
- Evaluate data on practitioners and provider denials
- Analyze HEDIS provider data
- Analyze, identify opportunities and recommend interventions to address provider satisfaction
- Monitor member and provider calls and feedback to identify potential network concerns
- Conduct surveys on appointment availability, after hour availability and open scheduling
- Recommend topics for review within provider communications

Managing and Improving the Network

We use an integrated, cross-functional approach in developing, maintaining and managing the provider network. We consider this critical activity a health plan-wide endeavor, integrated by interdepartmental monitoring processes and activities, business application systems accessibility and oversight committees structured with representatives from across the health plan. We continuously improve our network through member and provider feedback, innovation and routine monitoring. Below are several tactics we use to manage and improve the network:

- ***Build and Manage Network Operations:*** The network development team works continuously to maintain a network of providers capable of providing care in compliance with all DHH guidelines and requirements. The provider relations team oversees provider education and training, our provider call center, all of our high-touch provider service programs and monitoring of provider satisfaction. They ensure data points collected through day-to-day provider relations activities are applied to our operations.
- ***Educate and Train PCPs:*** We conduct trainings including new provider orientation and provider forums to educate providers on the benefits and requirements for all Bayou Health programs. Our provider relations staff communicates rules, regulations, resources and best practices with the provider's practice manager and designated office staff. We review the *Provider Administrative Guide* with all contracted providers and make it available through our provider portal, which includes comprehensive information related to care requirements, service specifications, provider responsibilities, billing information and practice guidelines. We also look for ways to tailor provider training to the population served. For example, we are working to establish a sickle cell disease (SCD) Center of Excellence in Louisiana, consisting of local providers and specialists with expertise managing SCD patients. This center of excellence will work to provide information and education to providers to improve the care and management of all SCD patients in the state.
- ***Establish Provider and Community Relationships:*** Our provider relations team educates hospitals and ancillary providers as well as looks for opportunities to partner with community providers and associations that can improve health outcomes for certain

members. For example, we recently invited statewide community and faith-based organizations, non-profits and others that work on the issue of teen pregnancy to a brainstorming session in Northeastern Louisiana to discuss ideas, issues and ways to ensure pregnant teens experience healthy pregnancies. By continuing these discussions in partnership with Children's Health Coalition of NE LA, we intend to develop a grant opportunity for community-based organizations to develop programs that along with patient-centered care can improve perinatal outcomes.

- ***Conduct Face-to-Face Visits and Confirm Compliance:*** Provider advocates are assigned a specific territory and are responsible for regularly meeting with providers. These meetings determine contractual compliance, including but not limited to medical records, appointment availability, physical environment, appointment wait times, advance directives and service delivery documentation. Staff from other departments may accompany the provider advocates on site visits to provide specific information and education to the provider. They also help address any issues or concerns providers may have about billing or authorizations.

Sustaining an Adequate Network

UnitedHealthcare's initiated network changes are planned, implemented and evaluated to ensure continuous improvement. We are developing and will maintain a provider network to meet DHH's provider network requirements statewide. We understand attracting and retaining high-quality providers is essential to sustaining an adequate network and we have undertaken initiatives to assist providers by addressing claims issues, answering questions, resolving complaints, streamlining information exchange and offering enhanced reimbursement models resulting in improved provider retention:

- ***Louisiana Health Information Exchange (HIE):*** As of August 21, 2014 we are live and receiving data from 44 hospitals participating with Louisiana HIE to populate our provider Population Registry. UnitedHealthcare is the only Bayou Health plan that has a contract with Louisiana HIE, and with the data feed now populating our Population Registry on a daily basis, we have an incredible opportunity to improve care transitions for our Bayou Health members.
- ***Enhanced Reimbursement Models:*** UnitedHealthcare is a national thought leader when it comes to value-based compensation (VBC) models and shares DHH's vision to close gaps in care and improve quality outcomes. Over the past several years our clinical model has evolved to incorporate new concepts with an emphasis on efficiency, value and accountability. Clinical management is shifting away from reactive individual patient transactions to proactive transactions that integrate care delivered by all providers for a targeted population. We recognize these changes in the health care environment afford us an opportunity to create more collaborative provider partnerships through population health clinical models of care aligned with a pay for value approach.

  To advance this strategy we have developed a comprehensive suite of VBC models that span the clinical integration and reimbursement risk continuum. This modular approach allows us to meet providers where they are from affordability and quality improvement perspective as well as their operational sophistication. On a regular basis we will review market-wide provider performance data to identify providers who are appropriate for VBC incentive models. Our VBC programs balance standardization with market level customization aligned with the goals of Bayou Health.

The result of these initiatives is increased provider satisfaction by 10 percent in 2013 and an overall provider retention rate of more than 99 percent.

G.2 Describe how you will provide tertiary care providers, including trauma centers, burn centers, children's hospital, Level III maternity care; Level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. If you do not have a full range of tertiary care providers describe how the services will be provided including transfer protocols and arrangements with out of network facilities. (5 points)

We are confident in our ability to provide the required tertiary services, and committed to ensuring patients receive the necessary services in accordance with section 7.8.5.

Our commercial hospital network has more than 95 percent of the acute care facilities throughout Louisiana, which constitutes over 99 percent of hospitals statewide. We are leveraging our existing commercial network of tertiary providers to build upon our network for Medicaid members using both urban and rural-focused strategies. Additionally, because we have existing and longstanding relationships and contracts with many Louisiana specialists through our commercial products, we are using these relationships to recruit these medical sub-specialists for the Bayou Health program. We are currently contracted or in active discussion with all tertiary care providers in Louisiana, ensuring we can cover the full range of tertiary services necessary for patients with complex diseases who may require high-risk pharmacologic regimens, surgical procedures, organ transplantation, trauma surgery, high-dose chemotherapy, some reconstructive or neurosurgeries, severe burn treatments or other specialized treatments or procedures.

Network Development Plan for Tertiary Care (7.8.5)

As part of a complete network strategy, we understand the importance of including a full range of tertiary care providers to ensure access and improve outcomes for Louisianians with complicated health conditions. Further, we recognize the need to assist members with access to tertiary care providers when no providers are located within their communities. Our network development strategy includes contracting with all types of tertiary care facilities to provide access for all Louisiana Medicaid members. We are currently in negotiations or have contracts with all hospitals located in Louisiana, many of which offer tertiary care services.

Our contracted status for tertiary providers is summarized in the following table by provider type:

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Ensuring Access to Tertiary Services

The nature of tertiary care means fewer providers may be available in certain areas to deliver the highly specialized care required. For example, many tertiary care centers are located in large, urban hospitals whose location may be an obstacle for residents in rural areas or smaller communities. When gaps in availability of tertiary providers, facilities and sub-specialists occur, whether due to a lack of providers in a specific area or absence of a contracted provider of a type in our network, we have processes in place to ensure access for Bayou Health members including transfer protocols and access to out-of-network providers.

Using Transfer Protocols

If a member is hospitalized and must be transferred to a tertiary care facility, the care manager works with the hospital case manager to arrange for the transfer to the tertiary care facility, including transportation which may require transport by ambulance or air ambulance.

In addition to transferring members to network providers for tertiary care services, members can also access out-of-network providers when necessary.

Using Out-of-Network Providers for Tertiary Care

When a member's needs cannot be met by a network provider, we do whatever is necessary to ensure care for the member, taking immediate steps to address the gap so the member's care is not compromised or interrupted. We agree to cover these services out-of-network for as long as we are unable to provide the services in network. In addition, we will initiate discussion and coordinate with hospital providers over the border of Louisiana, when appropriate and necessary to ensure access to care. We treat each member's circumstances individually, taking into account not only the special nature of the medical care needed, but also the linguistic and cultural needs of the member when locating a qualified specialist.

To mitigate potential delays in accessing urgent or emergency services for circumstances that threaten a member's health or welfare, we do not require prior authorization of services, regardless of a provider's network status. Members have the right to access care at any hospital, trauma center, or licensed emergency facility or urgent care center including any necessary transportation services.

G.3 Describe how you will keep all required provider information accurate and current, both internally and the information submitted to DHH for the provider registry. (10 points)

Ensuring Accurate and Current Provider Information (16.9, 14.5)

UnitedHealthcare recognizes the importance of accurate, timely and complete provider data as an important component of evaluating the effectiveness of our current partnership with the Bayou Health program and evidence we are fulfilling our responsibilities to DHH. We understand and will continue to comply with all requirements for submission of complete, accurate and timely provider data to DHH in accordance with all federal requirements and as specified in Section 16.9 Provider Enrollment and 14.5 Credentialing and Re-credentialing of Providers and Clinical Staff. Through the experiences gained in previous implementations, we have made significant improvements in our processes for loading and verifying provider data timely and accurately, and will continue to monitor and evaluate the effectiveness of those improvements.

Ensuring Internal Accuracy of Provider Information

Under the direction of chief operating officer Mr. Lirette, we use a multistep process to efficiently and accurately load and verify provider data according to DHH business rules. This process starts with the receipt of an executed contract, and includes verification of demographic information such as the National Provider Identification (NPI) and the Medicaid identification number. In addition, the verification process confirms the provider application and credentialing documentation is complete. Provider information is loaded into our National Database (NDB), a single enterprise repository of all UnitedHealthcare provider information, which feeds into our CSP Facets system enabling provider selection and claims payment. NDB includes a wealth of current and historical demographic and practice information for both participating providers and facilities including, but not limited to facility names, individual practitioner names, contract

effective dates, state Medicaid IDs, tax IDs, NPI numbers, practice locations, remittance address, telephone numbers, fax numbers, office or facility hours, email addresses and non-English languages spoken. As a primary function during implementation, we perform the following activities:

- Contract and claims testing to verify the configuration and fee schedule load
- Review installation accuracy controls and remediate defects
- Monitor end-to-end work flow using PhyCon, a new system designed to support physician contracting operations and provider demographic maintenance

UnitedHealthcare began implementing PhyCon early in 2013 to streamline the process of loading provider information into our provider systems. As a result, providers experience faster contract loads and increased satisfaction because they can see members more quickly and have claims processed in a timelier manner.

Our innovative and accurate provider contracting and credentialing process ensures we will completely process and load applications from all provider types within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement, per the requirements in Section 14.5.5.

Ensuring Accuracy of Provider Information Shared with External Parties

We currently coordinate provider enrollment records for our PCP network in Louisiana and will use our experience to apply this process to all contracted providers using the published list of Louisiana Medicaid provider types, specialty and sub-specialty codes in all provider data communications with DHH, the fiscal intermediary and the enrollment broker. We will provide the following data files:

- A weekly Provider Registry File to include provider name, address, licensing information, NPI, taxonomy, enrollment indicator, PCP indicator, accepting new patients indicator, and other data as detailed in the *DHH Systems Companion Guid*e.
- A weekly Provider Supplemental File, which provides additional information mandated by CMS for the T-MSIS project.
- A weekly Provider Site File as described in the *DHH Systems Companion Guide*.
- A weekly Primary Care Provider Linkage file as described in the *DHH Systems Companion Guide*.
- All relevant provider ownership information as prescribed by DHH, federal or state laws.

All required provider directory elements are extracted from our systems and published as described below to maintain compliance with specific requirements identified by DHH.

To confirm our data are timely, portable and readily accessible, several systems interface and provide the following data:

- Audit trail and history of changes made to the provider file
- Automated interfaces with all licensing and medical boards
- Automated alerts when provider licenses are nearing expiration
- Retention of NPI requirements
- System generated letters to providers when their licenses are nearing expiration

- Linkages of individual providers to groups
- Credentialing information
- Provider office hours
- Provider languages spoken

Identifying Medicaid-Eligible Providers

To ensure all providers are registered with Bayou Health to provide care to Medicaid members, a weekly audit is conducted to compare the Inbound State File with any change that may have been reported or input into any of the aforementioned demographic databases. Discrepancies in the data are investigated to determine accuracy and appropriate updates are made to the registry and submitted in our weekly registry submission to DHH. In addition, at least quarterly, a full review and audit is conducted prior to a complete new submission of a full file (not just updates) of provider demographic information to DHH. Claims from providers not enrolled with Louisiana Medicaid will be submitted with the provider's "Assigned Medicaid Provider ID", or the ID obtained from the registry response file sent from Molina to UnitedHealthcare.

We have experienced provider data analysts, who validate the data in the registry to ensure accuracy before it is submitted to DHH.

To support the need for accuracy both internally and in data provided to DHH for the provider registry, we will continue to attend and host a weekly meeting with DHH and DHH's fiscal intermediary, Molina, to discuss prevention of errors and correct any identified issues.

Strategies for Improvement

We are continually working to improve provider data accuracy and streamlining our processes – for both our State partners and our providers – to increase overall satisfaction and simplify program administrative so the emphasis is where it should be, on increased quality of care for our members and reduced costs for our partners and providers.

We identify provider data changes through a number of mechanisms including provider-initiated changes though our provider call center or submission via the online provider portal and through securing updates from the Council for Affordable Quality HealthCare (CAQH), National Plan & Provider Enumeration System (NPPES) or other industry sources of truth.

During 2014 we launched the Network Verification Initiative in Louisiana in which we compared CAQH provider data with the information in our system. As part of our in-depth review, we identified providers requiring outreach. Using a combination of fax and outbound calls, our initial verification activity in Louisiana was recently completed and resulted in more than 2,000 updated records. Other initiatives include developing a fully integrated feed between us and CAQH, educating providers about the value of maintaining current CAQH information, and establishing CAQH as the universal data source. Our goal is to implement CAQH as the industry source of truth and to streamline the provider's experience in working with multiple payers.

We are deploying additional tools and data mining capabilities to increase data accuracy including:

- Expanding proactive verification outreach campaigns to increase network coverage and data elements (including PCPs accepting new members status)

- Targeting intelligent data sourcing and analytics to remediate suspect data (e.g., no/low claims spend, age, cred status, last verification date)
- Leveraging portal and CAQH technology to centralize intake channels for contract and demographic data updates

Our team of provider data specialists work full time throughout the year reviewing and comparing our current provider registry demographic data with any other newly acquired data from any of these potential sources. Our provider contracts contain language that requires the provider to promptly report any change in demographic information to UnitedHealthcare.

Section H: Provider Management

H.1 Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times. (5 points)

UnitedHealthcare has an established, local market presence in Louisiana that enables us to provide the highest quality services to Bayou Health program providers. We continue to build upon the success of our existing program by expanding our provider network to include additional specialty areas to ensure access and improve the health outcomes for all members.

Ms. Tillman, provider claims educator, is responsible for ensuring compliance to all DHH requirements. She, along with her network development team and chief operating officer Mr. Lirette, has a process in place to routinely monitor appointment availability access standards as noted in section 7.2.

During the period from proposal submission to contract implementation, we will continue to add providers to our network as necessary to maintain and enhance appropriate program access and availability standards for all Bayou Health members. **Our current CCN-S provider network is 100 percent compliant with the State's geographic access requirements and has been for each quarterly report made to the state since inception in 2012.** Ms. Tillman is responsible for all requirements related to Section 7.5 including maintaining appointment and geographic availability monitoring and provider to member ratios. She will have leadership oversight for all written network policies and procedures, appointment standards (included in both the *Provider Administrative Guide* and provider contracts) and will oversee the quarterly GeoAccess reporting specified in Section 7.5 and Appendix UU.

Monitoring and Ensuring Adherence to DHH Requirements

We understand that timely access to care is essential for Bayou Health members and their families and we have programs in place to verify that members can reach a contracted provider during business hours. As noted in the table that follows, providers are informed during orientation of their contractual obligations to comply with appointment and wait time standards as specified in section 7.2. We also communicate this information in ongoing training and education such as the *Provider Administrative Guide* (our provider handbook), available online on BayouCloud, our provider portal.

Appointment Availability Access Standards for Care	Standard	Section
Emergent/Emergency	Immediately	7.2.1.1.
Urgent	Within 24 hours, seven days a week	7.2.1.2.
Non-Urgent sick care	Within 72 hours or sooner	7.2.1.3.
Routine/Non-Urgent/Preventive	Within six weeks	7.2.1.4.
Specialty Care Consultation	Within one month of referral not to exceed three weeks	7.2.1.5
Lab, X-ray Services	Not to exceed three weeks for routine appointments; 48 hours for urgent/clinically indicated care	7.2.1.6.

Appointment Availability Access Standards for Care	Standard	Section
Maternity Care	▪ Within first trimester:14 days ▪ Within second trimester: 7 days ▪ Within third trimester: 3 days ▪ High-risk pregnancies: within 3 days of identification of high risk or immediately if emergency	7.2.1.7.
ED Follow-up	In accordance with attending physician	7.2.1.8
In-office Waiting Time	Not to exceed 45 minutes	7.2.1.9.
Provider delay	Patients will be offered a new appointment if wait times exceed 90 minutes due to a provider delay	7.2.1.10.
Non-Urgent Walk-in Patients	Scheduled for an appointment as noted above	7.2.1.11.
Toll-free Telephonic contact	Availability 24 hours a day, seven days a week	7.2.1.12

We will continue to monitor provider compliance with appointment availability requirements and wait time standards in a number of ways to confirm care access or to identify gaps. We use member feedback through our care management team, quarterly service availability surveys and geographic access and availability studies. In keeping with our core values, we also monitor member outcomes related to appropriate access to care.

Provider Compliance Surveys

To evaluate provider compliance with availability requirements, we contract with McGahee & Associates (M&A), Inc., a vendor with expertise in monitoring provider compliance with appointment availability standards. In 2013, M&A conducted telephone surveys of high-volume providers. The results of the study indicated that **86 percent of providers are compliant with appointment availability standards.**

Assuring Provider Compliance

Provider compliance results are measured against state requirements and in accordance with our internal appointment and access policy. These results allow us to confirm provider adherence with contract requirements and provide a foundation for understanding where we need additional educational efforts, network development efforts or both. The results help us to:

- Identify accessibility trends by market or by provider type
- Customize provider education specific to each market
- Compare survey results to determine the effectiveness of past interventions

Results are presented to the Quality Improvement Committee (QIC) for review along with proposed interventions and potentially, corrective action planning. The QIC, working with the network management team may elect to establish interventions (e.g., provider education, site visit) or corrective actions. As part of our continuous effort to improve quality and access to care for all members, we may re-survey providers once corrective actions have been implemented.

Other Provider Compliance Monitoring

In addition to provider survey efforts, we have a supporting mix of monitoring techniques to verify that our network meets required access standards – both appointment availability and wait times – resulting in adequate and timely access to care. Through careful review of these reporting mechanisms, written policies and procedures, and our contractual relationships with providers,

we identify gaps and quickly identify, develop and implement action plans to resolve potential access issues. These include:

- PCP to member ratio reports
- Reports of provider panel size
- Member and provider satisfaction survey results
- Feedback from member services, case managers and other Louisiana-based UnitedHealthcare staff
- Feedback from network providers and partners through our provider grievance and appeal communication
- Member satisfaction survey questions through CAHPS
- Single case agreements
- HEDIS data
- Medical records reviews for targeted PCPs
- Clinical team feedback
- Provider on-site reviews (as needed)
- Claims data
- Surveys
- Appointment reminders and outbound member contact

When availability standards are not met, provider advocates conduct outreach and education to providers to reinforce standards compliance.

Practitioner accessibility and availability monitoring is conducted on an ongoing basis to measure performance against established standards for reasonable geographic location of practitioners, number of practitioners, appointment availability, provision for emergency care, and after hours service. Specific deficiencies are addressed with a corrective action plan and follow-up activity is conducted to reassess compliance. Data are presented by network management or quality improvement staff to the Service Quality Improvement Subcommittee (SQIS) for recommendation. This committee is chaired by Mr. Lirette; Ms. Tillman also serves on this committee and is integrally involved in monitoring and providing data to the SQIS for decision making about corrective action; Larry Smith, program integrity officer, serves on this committee as well.

A critical part of the role of the Provider Advisory Committee (PAC), also a Quality Improvement (QI) subcommittee, is overseeing the quality of care for Bayou Health program members. This includes providing program direction and continuous oversight of QI activities related to the unique needs of members and providers in the areas of clinical care, patient safety, and network credentialing and re-credentialing. Both the SQIS and the PAC have final recommendations approved at the Quality Management Committee (QMC).

H.2 Describe your provider grievance and appeal process. (10 points)

Our provider grievance and appeals process will include and comply with each specification and requirement outlined in section 10.6 Provider Complaint System. The process includes the ability for providers to submit complaints, grievances and appeals. These processes will give providers

both an informal and formal mechanism for dispute resolution. Since 2012, under the direction of provider services manager Ms. Thurmond, who is our key staff member designated to receive and process provider complaints, and Mr. Lirette, who has the authority to administer the provider complaint process, we have operated a provider complaint and state fair hearing system that complies with Louisiana's provider complaint and state fair hearing requirements.

We proactively collaborated with the Division of Administrative Law and DHH to implement a provider state fair hearing process in 2012.

In the first two quarters of 2014, we have received 184 provider complaints, resolved 210 (26 were carried over from 2013) provider complaints, participated in 83 provider state fair hearings and reversed our decision in a provider's favor through the state fair hearing process 27 times. The Division of Administrative Law (DAL) has not overturned any UnitedHealthcare decisions as a result of a state fair hearing review in 2014.

Because we do not currently process provider appeals, we will expand our current provider complaint and state fair hearing system to accept and process provider grievances and appeals using systems and processes currently in use in Louisiana and by leveraging our national provider grievances and appeals best practices based on 32 years of Medicaid experience and the 4.8 million Medicaid members we serve today.

We understand improving access and processes for our providers translates into greater provider satisfaction, which in turn translates into improved quality of care for members. Our comprehensive complaint, grievance and appeal system affords our providers recourse for having issues addressed, documented, investigated and resolved in a professional, timely, consistent and uniform manner.

Our system for providers, non-contracted providers and subcontractors defines provider's rights, including their right to file a request for a state fair hearing. We will submit our provider complaint, grievances, appeals and state fair hearings process and policy to DHH for review and approval within 30 calendar days of the date the contract. Our provider complaint, grievance, appeals and state fair hearing system:

- Complies with Section 10.6 including applicable definitions, written policies and procedures, a process to educate providers and compliance with the state fair hearing process
- Includes oversight by our Louisiana-based chief operating officer, provider services manager and team of provider advocates
- Includes oversight by our QMC and SQIS to we monitor, track and trend provider complaints
- Uses the definitions set forth in Section 10.6.1 and adheres to the requirements and timeframes required by Section 10.6 and federal regulations

Dedicated Provider Support Staff

In accordance with Section 10.6.4.1, we have implemented a fully staffed Louisiana-based provider relations team, discussed later in this section, which is readily available to support providers by answering questions, promptly resolving problems, and conducting outreach and education about UnitedHealthcare, including the tools available to providers to effectively conduct business with us and our programs, policies and procedures.

Receiving, Investigating and Resolving Provider Complaints and Grievances

We understand and acknowledge that:

- A provider complaint is any verbal or written expression, originating from a provider and delivered to any employee of UnitedHealthcare, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by UnitedHealthcare, excluding request of reconsideration or appeal for specific individual claims. It does include general complaints about claim payment policies.

> Through Q1 2014, our provider advocates have conducted **12,574 touch points** to providers statewide since program inception.

- Request of reconsideration or appeal for specific individual claims are considered provider appeals. We present our provider appeals process later in this section.
- A provider grievance includes the expression of provider dissatisfaction with general policies and actions of UnitedHealthcare and is a dissatisfaction formally filed with UnitedHealthcare according to procedures that we establish. A grievance is also a provider complaint that could not be resolved through the complaint process.

Complaint Process

In accordance with Section 10.6.5.1, providers must submit complaints within 30 calendar days of the event causing dissatisfaction. We request that providers submit complaints to us through our provider services center or via mail. However, we understand that provider complaints can come from a variety of sources and we ensure that the complaint is logged in to our complaint tracking system to ensure timely resolution of the complaint and continually improve our complaint resolution processes. We accept and log provider complaints, regardless of the method the provider uses to communicate a complaint to us, as follows:

- For complaints received in the provider services center, provider phone representatives log the complaint into our complaint tracking system, which routes the complaint to our provider complaint team.
- For complaints received via mail, our regional mail office scans the complaint and routes the complaint to our provider complaint team. The provider complaint team enters the complaint into our complaint tracking system.
- For all other complaints, the employee receiving the provider complaint (e.g., provider advocate, market service agent, case manager) will log the complaint into our complaint tracking system, which routes the complaint to our provider complaint team.

We will ensure that all UnitedHealthcare employees understand that they are responsible for ensuring that provider complaints are logged and addressed appropriately. Employees must log complaints into our complaint tracking system to ensure that we follow approved processes to resolve the complaint to the provider's satisfaction and in compliance with contract requirements.

Once the complaint has been logged in to the complaint tracking system complaint resolution analysts in our provider complaint team will investigate and resolve provider complaints. This process is presented in the provider complaint and grievance process flow in the figure below

and is compliant with Section 10.6.4.3. We will resolve all complaints and grievances within 30 calendar days, unless we have requested an extension, but no more than 90 calendar days. We resolve provider complaints as follows:

- The complaint resolution analyst acknowledges the provider complaint immediately, but no later than three business days from the time the complaint is received, regardless of the method the provider used to communicate the complaint.
- The complaint resolution analyst will investigate all pertinent facts related to resolving the complaint and, if the matter requires review by another UnitedHealthcare department, requests that a designated subject matter expert in the department address specific issues necessary to resolve the complaint.
- If we are unable to resolve the complaint within 30 calendar days, the complaint resolution analyst will notify the provider and Mr. Smith of the delay, present the outstanding issues; provide a timeline for resolution and a reason for the extension of the resolution time. The same will also be communicated to DHH in our monthly report of provider complaints, or sooner as needed.
- If the complaint resolution analyst is able to resolve the provider complaint, the complaint resolution analyst will verbally communicate the resolution to the provider and document the resolution of the complaint in our complaint tracking system.
- If the complaint resolution analyst is unable to resolve the provider complaint, the complaint resolution analyst will escalate the complaint to a grievance and transfer the grievance to our grievance and appeals team for investigation and resolution by a grievance resolution analyst.

Grievance Process

For provider complaints that our complaint resolution analyst escalates to a grievance or for any formal grievance filed by a provider, our grievance and appeal team will investigate and resolve the grievance as follows:

- The grievance resolution analyst will review the case in the compliant tracking system and will log the provider grievance in our grievance and appeals tracking system to monitor investigation and resolution, ensuring adherence to all contract requirements.
- The grievance resolution analyst will investigate all pertinent facts related to resolving the grievance and, if the matter requires review by another UnitedHealthcare department (e.g., clinical), the resolution analyst requests that a designated subject matter expert in the department address specific issues necessary to resolve the grievance.
- The grievance resolution analyst gives each provider a reasonable opportunity to present evidence and allegations of fact or law in-person, in accordance with Section 10.6.5.7, and in-writing. We date stamp and incorporate into the case file any information received during the resolution process. We give providers an opportunity to examine the grievance file, including any documents considered by us during the resolution process.
- If we are unable to resolve the grievance within 30 calendar days, the grievance resolution analyst will notify the provider and Mr. Smith of the delay, present the outstanding issues, provide a timeline for resolution and a reason for the extension of the resolution time. The same will also be communicated to DHH in our monthly report of provider grievances or sooner as needed.

- Upon resolution of the grievance, the grievance resolution analyst will provide notice of our decision to the provider.

The provider may appeal our decision regarding a complaint or a grievance provided the appeal meets the State's definition of a provider appeal. We resolve provider appeals following our appeals process, discussed later in this section.

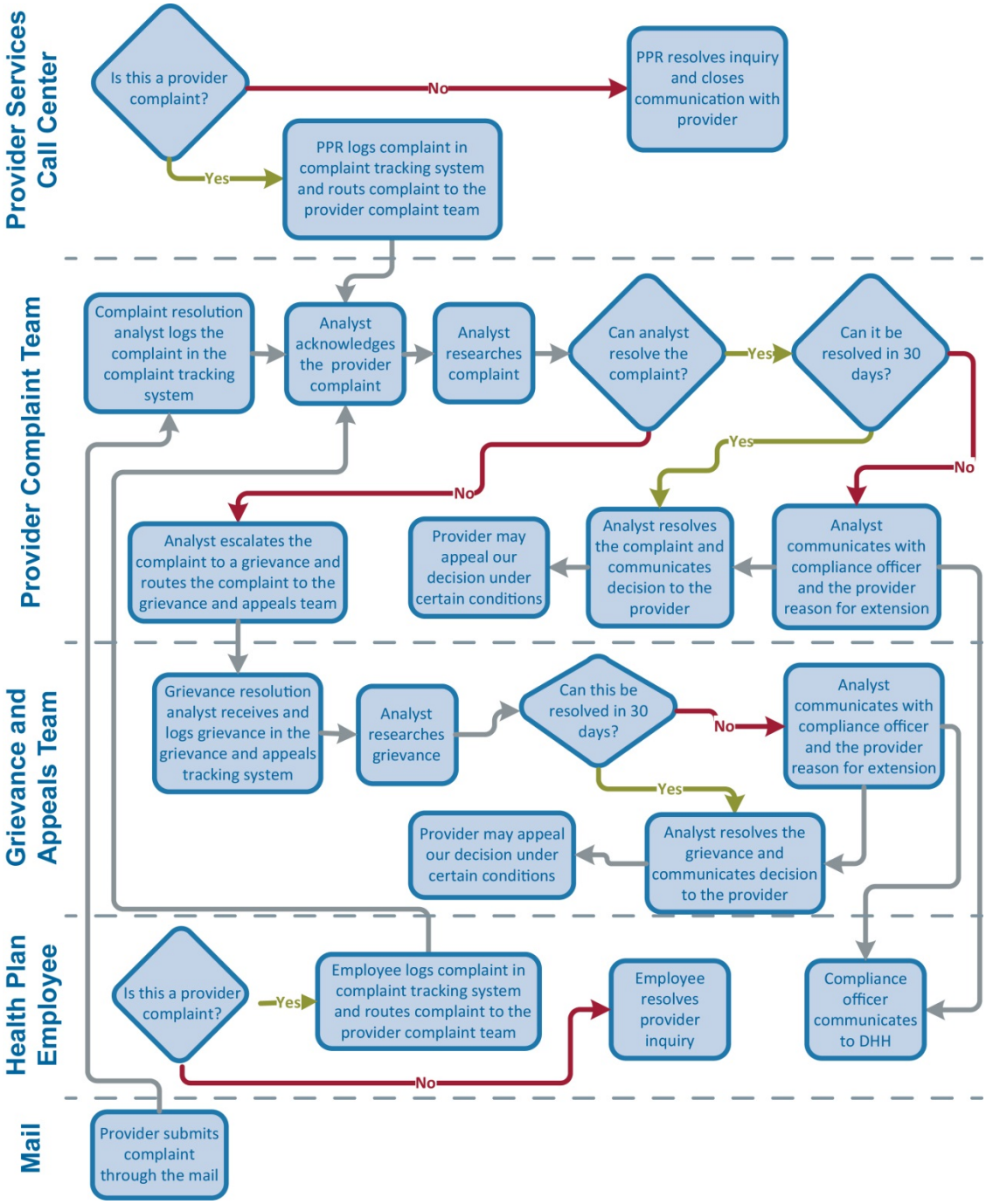

Figure 3. Provider Complaint and Grievance Process. Our comprehensive provider complaint, grievance and appeal process affords our providers recourse for having issues addressed, documented, investigated and resolved in a professional, timely, consistent and uniform manner. Provider complaints and grievances provide us with an opportunity to improve the services we provide to providers.

Essential to ensuring providers receive high-quality service and timely responses to their concerns, is our staff's ability to distinguish between a provider complaint and a member grievance or appeal in which the provider is acting on the member's behalf. In accordance with Section 10.6.5.3, we provide staff training on how to differentiate between a provider complaint, grievance or appeal and a member grievance or appeal in which the provider is acting on the member's behalf and how to address each of these issues appropriately.

How and Under what Circumstances Providers May File a Complaint

A provider may file a complaint any time the provider wishes to express dissatisfaction with our general policies and actions. In accordance with Section 10.6.5.2, we advise providers about how and under what circumstances they can file a complaint with us through provider training, the *Provider Administrative Guide*, our BayouCloud secure provider portal, provider advocate training, and outreach and provider phone representatives when providers call our provider services center.

Consolidating Complaints of Multiple Claims

In accordance with Section 10.6.5.4, a provider may contact a provider phone representative to file a complaint on one or multiple claims issues regardless of the number of individual patients impacted by the issue of dissatisfaction. A provider always has the option to submit a claims reconsideration request through our BayouCloud portal. This is the easiest way for a provider to receive feedback about whether a claim was paid correctly. Due to the ability to efficiently answer claim inquiries, we encourage all providers to submit a claim reconsideration request any time they believe claims were processed incorrectly.

Corrective Actions

In accordance with Sections 10.6.4.4 and 10.6.5.6, any complaint that cannot be resolved by the provider phone representative or resolution analyst will be escalated to Mr. Lirette, who has the authority to direct a corrective action.

Communicating Information about the Provider Complaint System

In accordance with Section 10.6.6, we will include a description of our provider complaint, grievance, appeal and state fair hearing system in the *Provider Administrative Guide* and through our provider website, BayouCloud. Providers may also request a hard copy description of our system. The description includes specific instructions on how to contact our provider relations staff and identifies Ms. Thurmond as the person who receives and processes provider complaints. Our provider education team also meets with new providers to supply them with a copy of the provider complaint, grievance, appeal and state fair hearing request policy, answer questions and ensure understanding of the process. For out-of-network providers, we communicate our policies and procedures with the remittance advice in accordance with Section 10.6.7.

System to Track the Receipt and Resolution of Provider Complaints

In accordance with Sections 10.6.2, 10.6.3 and 10.6.5.9, we use a complaint tracking system to log and track provider complaints and a grievance and appeals tracking system to capture, track and report all grievance and appeals activity, including policy-mandated timeframes for provider contact and appeal or grievance resolution. These tracking systems provide standard management reports to track our resolution timeframes and ad hoc query functionality. Using these tracking systems, we will continue to provide to DHH a monthly report on the status of all provider complaints and their resolution in accordance with Section 10.6.5.10.

In addition to capturing data about timeframes, we track the action or situation which caused the complaint to be initiated and use that data to trend the reasons why providers file complaints, grievances and appeals, enabling our management team to evaluate the need for policy and procedural changes or quality improvement. We use a multi-departmental trending and analysis of provider complaints, grievances and appeals data as a means to identify deficiencies within our operations and provider network and evaluate and develop interventions to improve performance.

Appeals

We understand and acknowledge that provider appeals include:

- Requests for the reconsideration and reversal of a UnitedHealthcare decision on a specific action or transaction, such as the denial or reduction of a claim, the imposition of a penalty or recoupment of payment, or the termination of a contract.
- Any post service appeal for the denial or reduction post service authorization or payments. A post service appeal is a denial of payment to a provider for services already rendered and for which the member cannot be billed.
- Any appeal for post-services authorization or denial of payment does not require consent of the member.

As presented in the provider appeal process flow (in the figure below), providers submit a written appeal within 30 calendar days of the event causing dissatisfaction. We date stamp the appeal and log the appeal into our appeals tracking system to ensure prompt resolution, including adherence to all contract requirements. Our appeals tracking system generates an acknowledgement letter, which is sent to the provider acknowledging the appeal. Our appeals tracking system then queues the appeal to a resolution analyst for investigation and resolution.

Our appeals resolution analyst gives each provider a reasonable opportunity to present evidence and allegations of fact or law in-person and in-writing. We date stamp and incorporate into the case file any information received during the resolution process. We give providers an opportunity to examine the appeal file, including any documents considered by us during the resolution process.

If the matter requires review by another department (e.g., claims), the appeals resolution analyst requests that a designated subject matter expert in the department address specific issues necessary to resolve the appeal. The resolution analyst may contact the provider to obtain information necessary to resolve the appeal.

Upon completion of this process, the appeals resolution analyst issues a written Notice of Appeal Resolution, which contains the results of the appeal resolution process, including the legal citations or authorities supporting the determination, the date it was completed and the provider's right to request a state fair hearing.

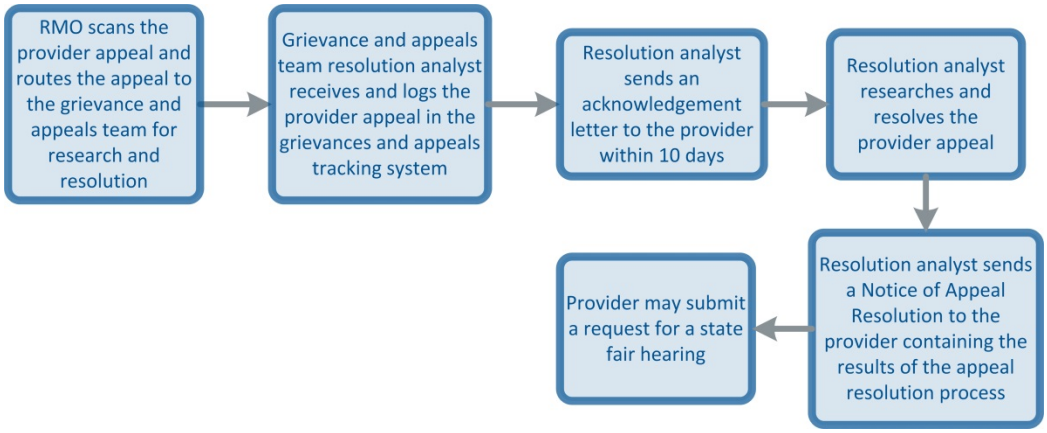

Figure 4. Provider Appeal Process. Through our provider appeal process resolution analysts investigate and resolve provider grievances. Providers may request a state fair hearing as a result of our decision under certain conditions.

State Fair Hearing

Any adverse action or appeal that is not resolved wholly in favor of the provider may be appealed to DAL for a state fair hearing. The written Notice of Appeal Resolution includes information that explains the provider's right to a state fair hearing and instructions for making such a request. Requests for state fair hearings must be made within 30 calendar days of receipt of the final decision by UnitedHealthcare.

As presented in the state fair hearing process (in the figure below), once a provider has filed a state fair hearing request with DAL, DAL forwards the provider's state fair hearing request to our grievance system manager, Coudra Costict, who is responsible for coordinating the investigation of the state fair hearing request, preparing the state fair hearing packet for DAL and attending the state fair hearing. If the provider submits the request to us, Ms. Costict forwards the request to DAL. Upon receipt of DAL's notification of the provider's request for a state fair hearing, we:

- Send an acknowledgement letter to DAL and the provider.
- Contact the provider to try to resolve the issue. If we are able to resolve the issue, we submit the reversal decision to DAL and send the provider a copy or our reversal decision.
- If we are unable to resolve the issue, we investigate the state fair hearing, including coordinating with the appropriate department (e.g., claims or clinical) for review and confirmation of our decision.
- If we reverse our decision as a result of our review, we submit the reversal decision to DAL and send the provider a copy or our reversal decision.
- If we do not reverse our decision as a result of our review, we prepare the state fair hearing packet for DAL, which includes a cover memorandum, summary of evidence and supporting documentation, and upload the state fair hearing packet to the DAL website.
- Attend the state fair hearing set by DAL. Additional UnitedHealthcare attendees may attend the hearing as needed.

We acknowledge that an administrative law judge at DAL conducts the state fair hearing. Upon making a determination, DAL will notify us, the provider and DHH of its decision. Following the state fair hearing, we update our grievances and appeals tracking system with the date and

final disposition of each state fair hearing resolution and close the case file retaining the data for six years. Since program inception, the State has only overturned one UnitedHealthcare decision as a result of a state fair hearing review. In the first two quarters of 2014, we have received 184 provider complaints, resolved 210 (26 were carried over from 2013) provider complaints, participated in 83 provider state fair hearings and reversed our decision in a provider's favor through the state fair hearing process 27 times.

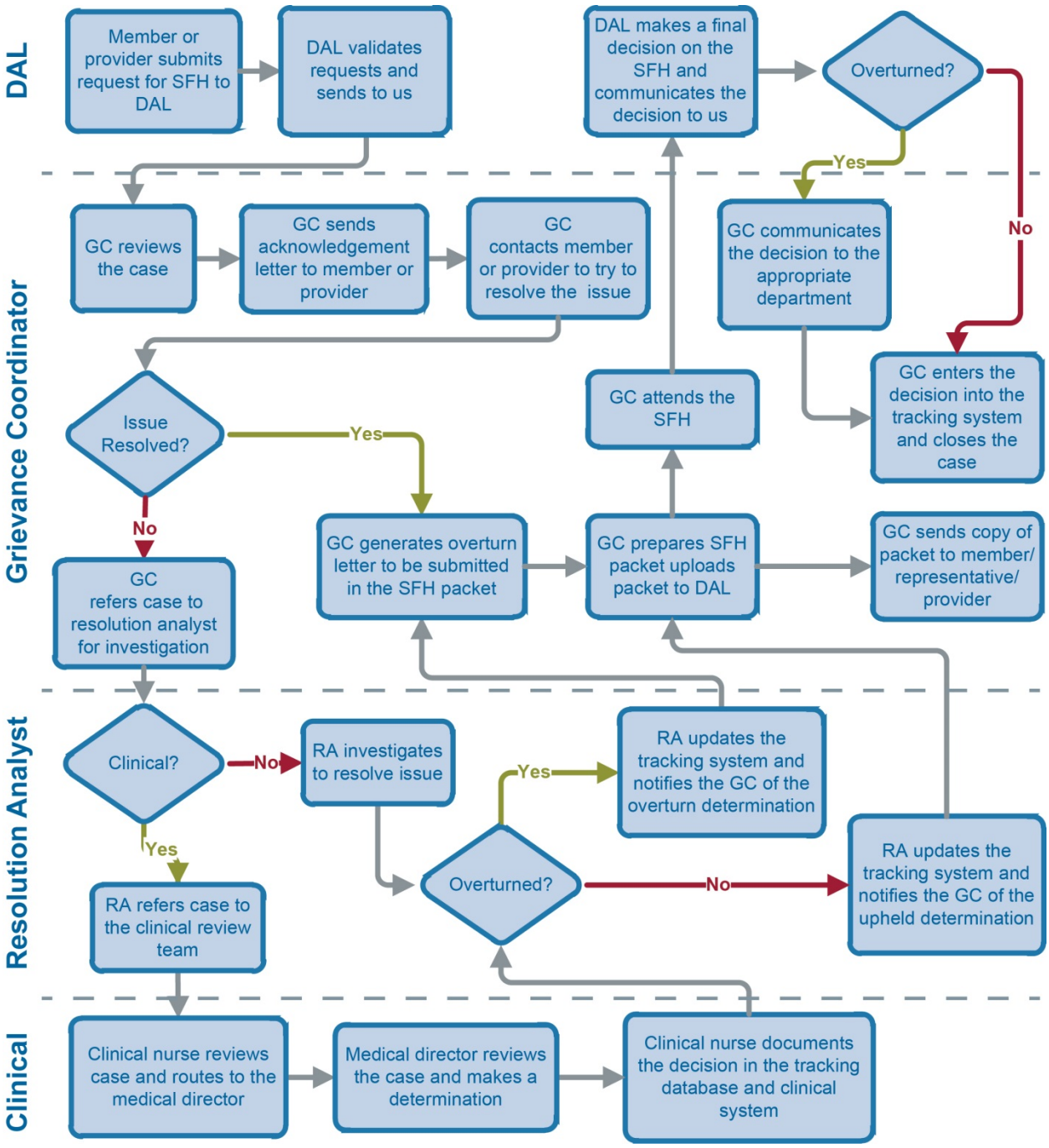

Figure 5. State Fair Hearing Process. Through our state fair hearing process, we investigate the provider's state fair hearing request to affirm or overturn our decision and attend the DAL state fair hearing to receive a final disposition of our appeal resolution.

Provider Service Model

In addition to implementing formal provider complaint, grievance and appeal processes, our approach to resolving provider complaints, grievances and appeals is to avoid situations that create provider frustration and, ultimately, lead to the lodging of complaints, grievances and appeals. We do this by implementing our Provider Service Model, which comprises systems, processes and provider support staff that give providers the information and support to efficiently conduct business with UnitedHealthcare. Through our Provider Service Model, we:

- Provide initial and ongoing education to ensure that all providers understand contract requirements and plan processes related to Bayou Health, such as provider billing requirements/claims processes.
- Implement systems and processes to pay claims correctly and on time.
- Give providers multiple options to submit and check the status of claims and service authorization requests 24 hours a day, seven days a week.
- Continually enhance provider tools that streamline and automate common tasks, such as service authorization submission and status, member eligibility, and claims submission and status.
- Provide a provider services call center and dedicated provider relations team that answer questions and works with providers to understand issues and resolve them.

Our Provider Service Model includes the provider services call center, provider support staff (comprising provider phone representatives, Louisiana-based provider advocates, market service agents, provider claims resolution specialists, claim project managers and our claims research team) and enhanced technologies to streamline and simplify the provider experience. We discuss each component of our Provider Service Model in the following sections.

Provider Services Call Center

Under the direction of Mr. Lirette, our toll-free provider services call center responds quickly to provider inquiries. Provider phone representatives, specifically trained in the Bayou Health program, staff the call center. Each time a provider calls, he or she speaks with a dedicated representative who has been thoroughly trained in provider services processes and the expected needs of most callers. Our toll-free call center is staffed Monday through Friday, 7 a.m. to 7 p.m. Central Time, excluding State-approved holidays. Through our call center, providers can obtain assistance on a wide variety of topics such as:

- Covered services, fee schedules and member eligibility verification
- Prior authorization and referral procedures
- Filing provider complaints, grievances and appeals
- Filing grievances and appeals
- Claims payment procedures and procedures for handling disputes
- Verifying member assignment to the provider's panel

Since February 2012, provider phone representatives in our provider services call center have handled more than 120,000 Louisiana provider calls with:

- An average hold time of four seconds, ***exceeding the requirement***
- An abandonment rate of less than 1 percent, ***exceeding the requirement***
- An IVR that ensures all calls are answered within 30 seconds, ***exceeding the requirement***

- Referring providers to the fraud and abuse hotline as necessary
- Coordinating the administration of out-of-network services

After hours calls to our provider services center are answered by our interactive voice response (IVR) system, which provides automated eligibility verification and benefits information. However, the primary source of provider information during and after business hours is our secure provider portal, BayouCloud. The provider portal offers access to interactive features such as claims submission and eligibility verification. The website also supports a wide variety of critical information, including the *Provider Administrative Guide*, provider directory and instructional materials. Both the IVR and the provider portal offer options for eligibility verification 24 hours a day, seven days a week on behalf of a member who may need immediate treatment for an urgent or emergent condition.

Dedicated Provider Support Staff

In accordance with Section 10.6.4.1, we have implemented a fully staffed Louisiana-based provider relations team that is readily available to support Louisiana providers by answering questions, promptly resolving problems, and conducting outreach and education about UnitedHealthcare, including the tools available to providers to effectively conduct business with us and our programs, policies and procedures. The team includes:

All new network providers receive a welcome call from a provider advocate. Provider advocates outreached telephonically to 2,405 providers to welcome them to our network at the inception of the plan and as they were contracted. This represents 100 percent of our currently contracted network.

- ***Provider advocates***, geographically dispersed throughout the state of Louisiana, conduct outreach, education and orientation for all new providers. They place introductory phone calls to all new providers to welcome their participation, answer any immediate questions and schedule an on-site, in-service meeting to provide orientation. Provider advocates routinely call upon providers to educate and support them on UnitedHealthcare processes and maintain positive collaborative relationships. Providers are encouraged to bring any questions or needs (e.g., updates to practice or personnel information) directly to their advocate for prompt handling. Led by Ms. Thurmond, we have three provider advocates, Dana Fisher, Melissa Chambers and Tracey Guidroz all of whom are dedicated to UnitedHealthcare and live in Louisiana.
- ***Market service agents (MSAs)*** support our provider relations and service interactions by working on end-to-end provider claim and call quality, enhancing the provider portal and other provider tools, developing provider training and education programs and assisting in the design and implementation of programs that build and nurture positive relationships between providers and UnitedHealthcare.
- ***Provider phone representatives (PPRs)*** are responsible for answering incoming calls from providers to resolve provider issues or provide answers to provider questions, ensuring a high level of customer service. Providers can obtain assistance from provider services representatives on a wide variety of topics, including filing provider complaints, grievances and appeals, and filing grievances and appeals on behalf of members.
- ***Provider claims resolution specialists (PCRSs)*** research provider claims issues, engage UnitedHealthcare departments to research and resolve claims issues, conduct outreach to

providers to gather additional information to resolve a claims issue and communicate the outcomes of claims issue resolution.

- ***Claim project managers (CPMs)*** provide end-to-end management of provider-based claim projects to resolve issues impacting providers with claims. They:
  - Communicate directly with the provider to understand the provider's expectation
  - Review impacted claims
  - Conduct root cause analysis to identify issues that are affecting claim payment
  - Verify that a solution has been implemented to allow correct payment
  - Identify all impacted claims and forward the claims to the claims research team for adjustments
  - Audit the results of claims research team reprocessing to ensure claims have been properly paid
  - Communicate the outcome of claims resolution to the provider
- ***Claims research team (CRT)*** completes adjustments on individual claims. The team:
  - Supports the claim project managers by adjusting claims identified by the claim project managers
  - Provides monthly metric reporting
  - Investigates defects that lead to high-volume claim payment issues

Streamlining and Simplifying the Provider Experience

We continue to pursue innovative solutions to streamline and simplify our provider administrative experience. Our BayouCloud technology is the next evolution of our online provider tools. Our BayouCloud website is the foundation of our goal to provide a single provider platform, bringing together multiple websites and incorporating new applications to improve efficiencies for our providers. With 24 hours a day, seven days a week accessibility, providers can use BayouCloud technology to conduct business with UnitedHealthcare any time it is convenient for them. By logging in once to a single and secure portal, providers can access all current online resources, plus new solutions aimed at streamlining and simplifying interactions, such as:

- ***Scheduling and Registration:*** This tool will link our authorization and claims payment systems, streamlining processes for prior authorization requests, including:
  - Performing a quick-check of whether or not prior authorization is required
  - Submitting electronic attachments of clinical records needed to support service requests
  - Communicating electronically with our clinical staff
  - Tracking the status of requests
- ***Eligibility and Benefits:*** This tool will eliminate the need for many provider phone calls by:

Our 2013 provider satisfaction survey resulted in an overall satisfaction rating of 84 percent. Our 2013 results showed a substantial increase in the percentage of providers responding to our survey and our overall approval rating increased by 10 percent over 2012.

  - Giving providers greater flexibility in member search features
  - Allowing providers to view deductible, out-of-pocket, copayment and coinsurance information
  - Giving providers tools to determine coordination of benefits information and know whether to apply in-network or out-of-network benefits based on the member and provider's relationship
- ***Claims Management:*** Providers will be able to manage their accounts receivable with greater ease due to more detailed information being provided and increased granularity and easy access to information will decrease claim inquiries and resubmissions. Features include claims search detail (payment/check info, edits, codes, line level payment); clear claim status remark codes; and additional reporting features to assist in account reconciliation.
- ***Claims Reconsiderations:*** Registered users of our BayouCloud portal will be able to submit claim reconsiderations with attachments, which saves time and money and provides seamless visibility to each reconsideration submission by providing confirmation of receipt and real-time tracking capabilities.
- ***Prior Authorizations:*** One of the exciting capabilities of our online technology allows providers to be notified for specific clinical information needed when submitting a procedure for medical necessity review and allows attachment of required clinical information at the time of submissions. It also confirms that clinical information has successfully been attached to the request once the clinical information is uploaded by the provider. And, provides for the ability to track the status of the request as it goes through the various steps of medical necessity review.

H.3 Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process. (5 points)

For inquiries and requests for information received outside of the grievance and appeals process, the employee receiving the request (e.g., provider advocates, clinical practice consultants, case managers, provider phone representatives) is responsible for responding to the request and assisting the provider. If the employee is unable to resolve a provider inquiry or request for information, the employee will escalate the request and log it into our complaint tracking system for resolution by our provider complaint team.

For complaints, we request that providers submit complaints through our provider services center or via mail. However, we understand that provider complaints can come from a variety of sources and we ensure that the complaint is logged in to our complaint tracking system to provide timely resolution of the complaint and continually improve our complaint resolution processes. We accept and log provider complaints, regardless of the method the provider uses to communicate a complaint to us, as follows:

- For complaints received in the provider services center, provider phone representatives log the complaint into our complaint tracking system, which routes the complaint to our provider complaint team.
- For complaints received via mail, our regional mail office scans the complaint and routes the complaint to our provider complaint team. The provider complaint team enters the complaint into our complaint tracking system.

- For all other complaints, the employee receiving the provider complaint (e.g., provider advocate, market service agent, case manager) will log the complaint into our complaint tracking system, which routes the complaint to our provider complaint team.

H.4 Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled.

- Submit sample quality profile reports used by you, or proposed for future use (identify which).
- Describe the rationale for selecting the performance measures presented in the sample profile reports.
- Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports. (10 points)

We engage in a variety of methods to profile the performance of our contracted health care providers. Profiling is used for utilization management, provider pay for performance and quality-of-care monitoring. We have written policies, procedures and proven processes in place to conduct provider profiling in compliance with the State's requirements specified in Section 8.12. This includes profiling for network and non-network PCPs; specialist referrals; ER utilization; hospital admissions, lab services, medications and radiology services; and individual PCP clinical quality performance measures as noted in Appendix J.

Today, for our quality program, we use provider profiling in three main ways:

- Identify opportunities for reducing variation in practice patterns
- Provide participating PCPs with information about their practice
- Integrate quality of care/peer review data into our credentialing processes

Assessing Variation in Practice Patterns

We monitor our participating PCPs against established clinical practice guidelines for acute, chronic and preventive care. Using our robust databases, we compare individual provider performance on quality process and outcome indicators. Our databases include:

- ***MedMeasures:*** our NCQA-certified HEDIS software system that provides interim and annual HEDIS rates to enable profiling against HEDIS standards.
- ***Universal tracking database (UTD):*** facilitates monitoring of compliance with preventive and chronic care standards at the member and provider practice level, provides a shared database for use by case management and quality management to educate members and provides the mechanism by which we can track interventions.

Specifically, HEDIS measures, which are designed to measure performance against accepted standards of clinical practice, can be applied to the individual provider or practice level to ascertain whether there are variations from expected performance (e.g., fewer pediatric preventive care visits that would be expected for a pediatrician). This data are reviewed by our quality management and performance department and shared with chief medical officer Dr. Ann Kay Logarbo. When opportunities are identified, our clinical practice consultants (CPCs), field-based registered nurses, meet with the provider and their office staff to review performance and the associated clinical practice guidelines and to identify opportunities to improve the practice's systems to improve compliance.

Provider Scorecards

Additionally, through our proprietary databases, we produce provider scorecards at least twice a year. Our experience is that sharing this data bi-annually provides an opportunity for our participating PCPs to view their performance in comparison to others in the network in measures of both utilization and quality. These scorecards provide an additional opportunity for further dialogue between our clinical staff and network practitioners related to improvement in quality performance.

Quality of Care/Peer Review

We maintain a quality of care/peer review process in compliance with state and federal regulations. When a potential quality of care concern is identified, it is referred to our clinical quality team for review and investigation. Cases are then reviewed with Dr. Logarbo and if a deviation from standard practice or potentially preventable adverse outcome is identified, the case is presented to our peer review committee (PRC). Our PRC includes participating UnitedHealthcare practitioners with a variety of clinical backgrounds. Based upon the PRC review of the case, a level is assigned and action is taken commensurate with the severity of the issue. All such issues are entered into our confidential database, QCare. In QCare, we are able to review a profile for individual providers who may have multiple quality of care concerns across all lines of business (e.g., Medicaid, commercial, Medicare). This database provides a comprehensive profile of a provider's performance, enabling us to make a determination regarding a provider's participation if an unacceptable quality of care trend emerges. Furthermore, upon a provider's tri-annual re-credentialing, this database is evaluated and providers who exceed our threshold for quality of care concerns are evaluated by our credentialing committee before a determination is made to re-credential.

The Future of Profiling

Anticipating award of the Bayou Health contract, we are developing prototypes to support expansion of our provider profiling program in Louisiana. This enhanced provider profiling program will focus on hospitals and specialists (e.g., obstetricians/gynecologists). For practitioners focused on women's health, while not assigned members like a PCP, we are evaluating the inclusion of episodes of care particularly around prenatal/postpartum care with the goal of continuing to improve our maternity outcomes. We are using best practices from across our organization to develop these profiles. Additionally, we are updating our nationwide patient safety work plan to further refine several elements to reflect the needs of our Medicaid beneficiaries and state partners. As part of this, we are anticipating hospital profiles, aligned with national patient safety objectives and our own hospital pay for performance methodologies. Such profiles may include:

- Mortality rate for three conditions based upon epidemiological assessment and collaborative discussion with hospital patient safety staff
- National Patient Safety and National Quality Forum
- Hospital CAHPS (HCAHPS)
- Early elective delivery

Quality Profile Reports

Please refer to Attachment H.4 for sample quality profile reports which include:

- ***Attachment H.4-1_HEDIS Reports:*** Illustrate provider/practice compliance with clinical practice standards.
- ***Attachment H.4-2_Sample Medicaid Acute Provider Profiling:*** Sent to providers/practices, these reports list various clinical measures and describe the provider's/practice's compliance with each measure.
- ***Attachment H.4-3_Sample Provider Profiling letter for OBs:*** Sent to obstetricians when provider performance in at least one measure is lower than anticipated.
- ***Attachment H.4-4_Sample Provider Profiling letter:*** Sent to providers when provider performance in at least one measure is lower than anticipated.

Rationale for Selecting Performance Measures

Provider profiles are made up of a standard set of utilization metrics and HEDIS measures based upon the level of importance. We typically choose quality measures based on State initiatives, performance improvement projects (PIPs) or other quality improvement goals identified.

For Bayou Health, provider profiles will include but not be limited to the following measures:

- Adolescent Well Care
- Adults' Access 45-64 years
- Chlamydia screening in Women
- Completed mammograms
- Completed pap smears
- Diabetes HbA1c screening
- Well child 0-15 months
- Well Child 3-6
- Well Child 7-11
- Well Child 12-21
- Adult BMI Assessment
- Follow Up Care for Children Prescribed ADHD Medication – initiation
- Follow Up Care for Children Prescribed ADHD Medication – continuation
- Diabetes Care: Eye Exam (Retinal) Performed
- Frequency of Postpartum Care

Proposed Frequency to Distribute Reports

Twice yearly, we will distribute the results of provider profiles to PCPs at the individual and/or practice level, depending on the size of the practice's assigned membership. The provider profile provides a snapshot of provider utilization patterns and quality scores. This is accompanied by a list of non-compliant members which details the need and measure for outreach – inclusive of all measures listed on the profile.

Our process, in addition to closing gaps in care, provides critical feedback and education to providers with support from the clinical practice consultant team. It rewards high performers and helps providers with lower scores gain the skills and understanding to move to a higher level of performance.

In addition, we will provide regular reports to providers participating in our value-based contracting models and work closely with those practices to ensure they are supported in achieving the targeted results. This is described further in Section Z of our proposal.

Finally we report monthly during Joint Operating Committee meeting to our Accountable Care Community practices to review performance results for the practice and their clinics. We follow a Plan-Do-Study-Act approach in addressing quality and utilization gaps.

H.5 Describe how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers. Identify the key requirements that will be addressed. (5 points)

We have a comprehensive provider education and training program that begins when the provider first contracts to join our network and provides ongoing general and targeted education and training. Our provider orientation process verifies through a variety of methods (like face-to-face meetings, webinars and community forums) that our providers understand contract requirements, plan processes, claim submission and payment processes.

We agree to provide training to all providers and their staff in compliance with Section 10.5, Provider Education and Training. Through our training curriculum and information provided in the *Provider Administrative Guide* we focus special attention on identification of special needs of members and limitations on provider marketing. Our provider education and training program is built on over 32 years of experience with providers and multi-state Medicaid managed care programs. Our statewide provider training outreach effort will include a broad range of training opportunities designed to create an informed, high-quality provider network for Bayou Health members.

Educating and Training Providers on Billing Requirements

We have a well-developed provider training program that includes educational mailings, online seminars (starting in 2014), and on-site provider visits and group trainings. Our initial provider training **prior to the start of operations under this contract will** cover a number of subjects. In addition to **billing requirements** it includes such topics as cultural competency and how to obtain culturally relevant materials, how to use interpreter services for non-English speaking members, and how to obtain materials in alternate formats. Integration of physical and behavioral health care is also addressed, and coordination and referrals processes for carved-out benefits such as dental.

Initial Education

We provide orientation training to newly contracted providers and identify when new providers may have a lack of experience when working with managed care. In compliance with section 10.5.1, we educate and train new providers **within 30 days** of their contract effective date. Specialized training, both initial and ongoing, on **Bayou Health billing procedures** and service authorization requirements are part of our initial training efforts for new and current providers, in compliance with section 10.5.3. Our training program uses traditional approaches such as site/group visits and on-site town hall meetings and innovative methods such as webinars. In addition, our provider advocates host monthly town hall webinars that provide support and education as described below.

Town Hall Educational Trainings Continue to Meet Provider Needs

The team conducted a total of 132 town hall meetings at various locations around the state in Louisiana beginning in November 2011 through June 2012 as Bayou Health rolled out and went live. Each town hall had 10 to 80 attendees. We estimate that more than 5,200 provider representatives attended at least one town hall meeting.

After the first four town halls, the feedback we received prompted us to change our format. Based upon this provider feedback we **added a clinical component to the town halls. We also developed "Frequently Asked Questions" brochure that we handed out at all town halls. These FAQs were continuously revised and expanded to accommodate additional FAQs as we progressed**. Providers were pleased with the revised town halls. Chief medical officer Dr. Ann Kay Logarbo also attended several to address questions at the end of the town hall.

All town halls had a question and answer period at the end which was used to improve subsequent town halls and also acted as a gauge for provider satisfaction. In addition, we were the first Bayou Health plan to conduct town halls. Providers expressed they were very pleased with our accessibility.

The provider advocate team also attended:

- State-requested meetings designed to educate providers statewide on the roll out of Bayou Health
- State-sponsored meetings from inception of Bayou Health to collaboratively assist with issue resolution and education
- State-sponsored calls from inception of Bayou Health to present.

In calendar year 2012, the advocate team conducted 1,285 face-to-face provider meetings. Our provider relations team assesses each provider's training needs at the time of contracting and conducts in-person training if needed. We provide initial training to newly contracted providers and identify when new providers have a lack of experience working with managed care. To reinforce initial training, we offer ongoing training for all network providers. **The provider advocate team** is an important part of this outreach effort: they have **made 12,574 provider contacts statewide** since the inception of the Bayou Health program.

Connecting with Providers

To reach busy providers throughout the state of Louisiana, we use a five-touch approach to connect with providers that includes: 1) welcome letter, 2) telephonic outreach, 3) face-to-face appointments, 4) webinars and 5) town halls.

Provider Relations Team

Led by Mr. Lirette, with clearly defined territory and provider assignments, the provider relations team includes Ms. Thurmond, provider services manager, and three full-time provider advocates -- Dana Fisher, Melissa Chambers and Tracey Guidroz -- all of whom are dedicated to UnitedHealthcare and live in Louisiana. Ms. Fisher, Ms. Chambers and Ms. Guidroz spend most of their work time in the field, meeting with network providers to build relationships, answer questions and identify areas for improvement. They visit high-volume primary care sites on a weekly basis and all sites on a regular basis. In addition, Dr. Logarbo visits hospitals and providers serving a high volume of our members and other providers as needed. These visits address provider needs, allow a forum for feedback and give us the ability to gauge program effectiveness in given regions. Dr. Logarbo's involvement in the community is another

mechanism for feedback and perspective. As we are able to integrate behavioral health in to our plan offerings, the behavioral health medical director will also meet with identified quality providers to recruit them into the network.

The provider advocate team provides basic training around billing processes and authorization requirements and procedures, and will escalate issues requiring more technical or administrative expertise to navigate the issue through resolution. Additional resources have been built into our model to improve our ability to adjust to any increases in training needs brought about by significant changes or other broad impact provider issues. Our network partners are available to augment the provider advocate team and additional business analysts are available to provide specific, detailed technical training related to the electronic data interchange (EDI), electronic funds transfer (EFT) and other escalated issues.

Figure 6. Dr. Ann Kay Logarbo (left), chief medical officer, participates in a brainstorming session with community partners regarding preterm births. (July 2014)

Improving Claims Processing and Payment Training

We recognize the need for additional training for some providers with the transition from legacy Medicaid to Bayou Health. To ensure these providers get the training and assistance they need, our provider advocates work throughout the State with providers to educate, train and provide ongoing support with claim/billing requirements and issues. We provide training to newly contracted providers and recognize when new providers may have a lack of experience when working with managed care.

In continuously looking for opportunities to improve our claims submission processes, we leverage a variety of methodologies that also help our providers be more efficient and accurate in their claims submissions, including:

- ***Claims Lab Training:*** We conduct claims lab training sessions for providers, many of whom are unfamiliar with electronic claims submission processes. This hands-on training promotes accurate claims submission, thereby improving claims payment turnaround times and better tracking of the claim submission process.
- ***Online/Phone Claims Status:*** Providers can access the status of their claims via telephone or on our provider portal, BayouCloud 24 hours a day, seven days a week.
- ***Provider Education:*** We provide ongoing education on the benefits of electronic claims submission through in-person contact, training materials and provider newsletters.
- ***Claims Deep Dive Initiative:*** We conduct an annual audit of all standard operational procedures relating to claims processing.
- ***Innovative Claims Management Self-Service***

> "I often find myself asking other carriers if/when they will be releasing a product like the Cloud. The fact that we can submit reconsideration online and attach documentation is a huge time saver for us. Claim status and eligibility are also wonderful features. The number of customer service calls I make has been drastically cut by using the Cloud."
>
> *-- Cloud dashboard user*

Solutions: The BayouCloud dashboard is the next evolution of our online tools, where new features and functions will be added through our strategic partnership with Optum, a leader in innovative health care technology solutions. BayouCloud portal, a cloud-based website, is the foundation of our goal to provide a single provider platform to bring together multiple websites and incorporate new applications to simplify transactions. With 24 hour a day, seven day a week access to BayouCloud, provider offices are able to conduct business with UnitedHealthcare on their time and when it is convenient for them. By logging in once to a single and secure portal, users will be able to access all current online resources, plus new solutions aimed at streamlining and simplifying the way we interact. Claims management features of this application include:

- Flexible search capability for paid, denied, pended and closed claims
- Claims search detail (payment/check info, edits, codes, line level payment)
- Clear claim status remark codes
- Claim reconsideration link
- Flag claims for future follow-up and the ability to print and export data

BayouCloud Claims Support

Through our BayouCloud, secure provider portal, providers can view and update their provider profiles, check member eligibility, submit claims, check claims status, request claim adjustments, view claim trends and view summary data. BayouCloud claims administrative tools include:

Feature	Description
Provider Demographic Changes	Submit changes to demographic information via portal
Member Eligibility	Look up member's eligibility and benefits online
Claim Status Inquiry	Look up the payment status of individual claims or a batch of claims
Claim Submission via Web	Enter and submit individual claims or batch of claims
Display Payment Remittance	Query/view remittance information
Claim Adjustment Requests	Request a single or multiple claim adjustments (prior to formal dispute)
Display Recovery Projects	View a list of the claims we are recovering funds from the member
Claim Trends	View claim trends and summary information
Display Authorizations	View UnitedHealthcare care authorizations and service accumulators
Submit Authorizations via Web	Submit authorization requests online via our provider portal

Ongoing Provider Training

We offer ongoing education for all providers biannually in compliance with Section 7.9.5.7. We have a well-developed provider orientation program that includes educational mailings, online seminars, and on-site provider visits and group trainings. Our initial provider training covers a number of subjects, including cultural competency and how to obtain culturally relevant materials, how to use interpreter services for non-English speaking members, and how to obtain materials in alternate formats. Integration of physical and behavioral health care is also addressed.

Ongoing training to providers and their staff is essential as we transform the Bayou Health delivery system. We conduct provider education and trainings through face-to-face meetings, group sessions, town halls, mailings and fax. We have been proactive and industry leading in developing specific ICD-10 training. Finally, we provide a dedicated EDI hotline as a convenient method for providers to receive electronic claims support through our EDI support team.

After the initial provider training, our provider relations team remains in frequent communication with our providers through mail, phone and fax to update them on program changes, answer their questions and maintain current provider contact information for the provider directory (e.g., office hours, location, contact information and panel status).

We educate providers on the importance of making us aware of changes and provide them with the network resource team contact number to report changes. In addition to regularly scheduled meetings, our staff meets with providers one-on-one to provide focused training that addresses any concerns and issues related to outlier data and potential non-compliance. For example, we proactively identify outlier billing and coding trends and follow up with providers to offer guidance and support. We send all network providers, including those who have attended these training sessions, an educational packet and instructions related to pursuing additional provider training opportunities. Other modes of ongoing training include:

- ***Provider Training Manual (Provider Administrative Guide):*** All network providers will receive a printed copy of the provider training manual upon request in compliance with Section 10.5.2 which will be submitted to DHH for approval within 30 days of the contract signing date. The *Provider Administrative Guide* will be posted on BayouCloud. The *Provider Administrative Guide* includes information about the Louisiana program benefits and our policies and procedures, and information regarding payment terms and utilization review. The *Provider Administrative Guide* has been and continues to be revised as we develop or change information relative to the administration of the plan.
- ***Provider Newsletter (Practice Matters) and Service Bulletins:*** Also included in training and educational information is our quarterly provider newsletter. *Practice Matters* contains program updates, claims guidelines, information regarding policies and procedures, cultural competency and linguistics information, clinical practice guidelines, information on special initiatives and articles regarding health topics of importance to members. The newsletters also include notifications regarding changes in laws, regulations and subcontract requirements. The service bulletins are also listed on BayouCloud and recapped in *Practice Matters*.
- ***BayouCloud Provider Portal:*** Our Web-based provider portal BayouCloud will support Louisiana Medicaid providers through many innovative features and tools and is integrated with our critical systems. Our interactive website enables providers to electronically determine member eligibility, submit claims and ascertain the status of claims. The provider portal will contain an online version of the *Provider Administrative Guide,* the provider directory, clinical practice guidelines, quality and utilization requirements, and educational materials such as cultural competency information, newsletters, recent bulletins and other provider information. We also post notifications regarding legal changes, regulations, bulletins and alerts.

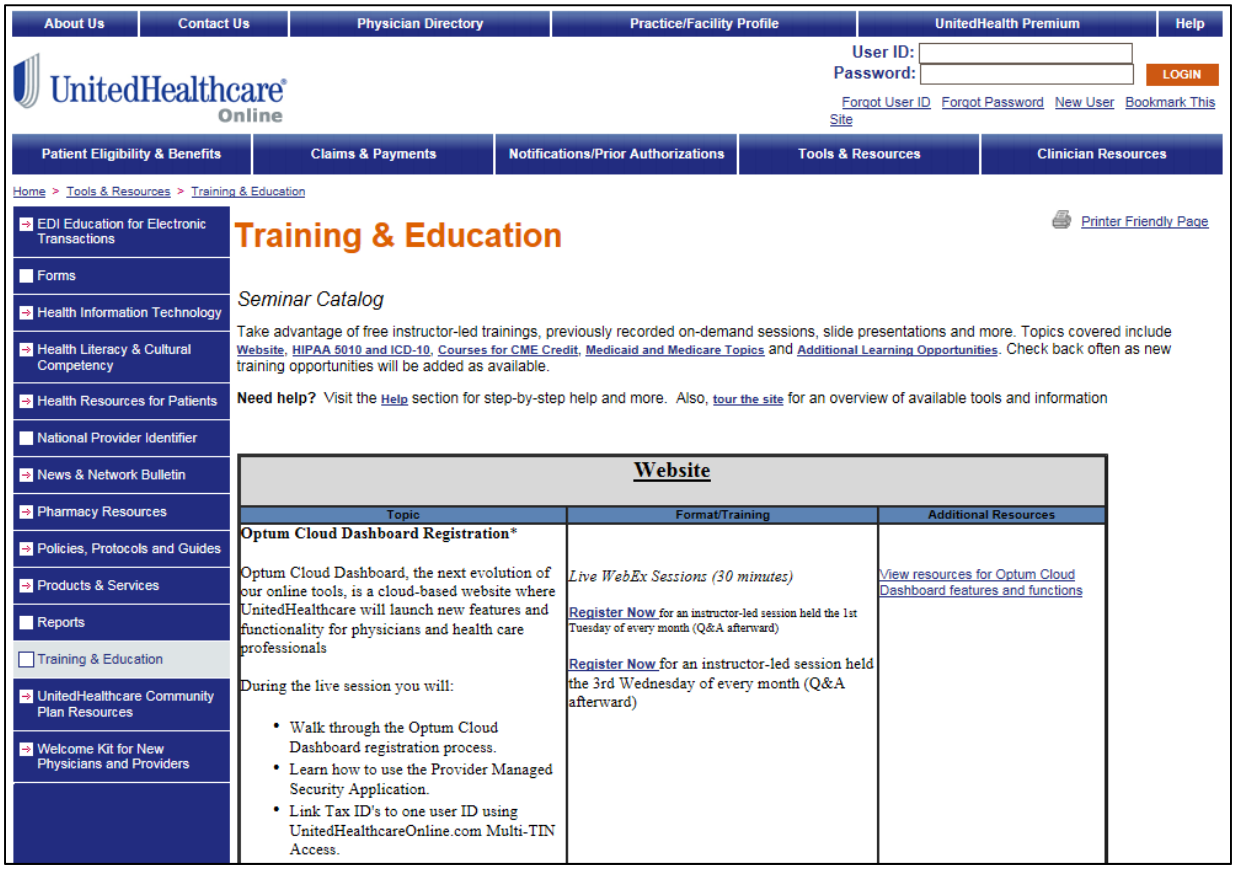

Figure 7: On-Demand Provider Training is available through BayouCloud.

- ***Field-based provider training:*** Field-based training is an important component of our continuous quality improvement efforts. We schedule routine trainings and educational forums to touch our providers and facilities. The provider advocate team holds at least monthly meetings with high-volume providers to present regular updates and refresher trainings. We hold Joint Operating Committee (JOC) meetings with key facilities to address operational issues, including training needs. Provider advocates schedule meetings as needed with primary care practices to ensure critical policies and procedures are reviewed and access and availability information is gathered, and to discuss any other pertinent issues. In addition to standard training, both scheduled and requested, the issue resolution tracking (IRT) process provides a mechanism for us to identify special provider training needs through root cause analysis of claims issues identified by or referred to us. Through identification of claims issues with provider error as the root cause, we schedule a special in-office training to address the issue and provide resource materials and instructions specific to the billing error.

Key Training Requirements

One of the ways we build and maintain a high performing network of providers is through our initial and ongoing training. The health care system is undergoing a tremendous amount of change and we adapt training programs to meet the needs of this change. We consult, we educate and we collaborate with providers based upon *where they are* – in terms of creating training programs that meet their busy personal and professional lives and in terms of where they are in the learning curve. New provider training topics and requirements include, but are not limited to:

Training Requirement	Training Topic
Billing	Provider billing requirements/claims processes
	Proper completion of billing forms
	Prohibition to balance bill members
	Correct billing for HEDIS related services
Claims	Understanding the Provider Claims Service Unit process
	Timely filing requirements for submission of claims
	Submission process for corrected claims
	Claims mailing address/EDI submission requirements
Service Authorization	Service Authorization
	Emergency services not requiring authorization
Network Management	Provider Basics
	UnitedHealthcare network requirements
	Referral management and preauthorization procedures
	Provider rights and responsibilities
	Treatment/medical record documentation requirements
	PCP selection procedures
	Web based tools, clinical tools, evidenced based medicine
	Access/availability requirements; including ED diversion
	Medical home model
	Use of the provider Web Portal
COB	TPL/Coordination of benefits process and requirements
HIPAA	HIPAA compliance expectations and protocols
	HIPAA coding requirements
Cultural Competency	Cultural competence
	Requirements for language interpretation/translation
	Special needs accommodation
Enrollment/Eligibility	Member enrollment/eligibility verification procedures
Administrative	Important contacts for UnitedHealthcare
Special Programs	Special Programs (DM, performance improvement projects)
Care Management	Coordination with CM program and specialty
	DM and CM programs (e.g., Healthy First Steps)
Prenatal Care	Timely provision of prenatal care
Electronic Data Interface	Working with EDI (Electronic Data Interface)
National Provider Identification	Importance of NPI (National Provider Identification).
Quality Management	Quality management participation and improvement initiatives

UnitedHealthcare will also provide education to all participating providers on the quality metrics that the state of Louisiana has identified relative to its membership, and any additional areas of quality performance improvement that we have identified. This will include written explanation

of how the quality metrics are calculated. Ms. Thurmond's staff will continue to reinforce this education during meetings with network providers.

Assessing Training Effectiveness

Through provider complaints, staff feedback, trended claims data, associations and provider advisory councils, we identify common topics or opportunities for retraining and specific providers for focused retraining. We monitor to ensure effectiveness and provide additional education when we identify common issues of interest. We communicate to all providers on relevant training topics and update our training curriculum on an ongoing basis to better communicate information especially on common issues such as billing and eligibility verification. As referenced in our town hall description, we listen to providers and adapt our training based upon their feedback and the usefulness of the information we present.

Part V: Benefits and Member Management

Section I: Member Assessment and Care Coordination

I.1 DHH intends to provide MCOs with two years of historic claims data for members enrolled in the MCO effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your MCO effective February 1, 2015. The description should include:

- How you will identify these enrollees, and how you will use this information to identify these enrollees, including enrollees who are receiving regular ongoing services;
- What additional information you will request from DHH, if any, to assist you in ensuring continuation of services;
- How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation;
- What information, education, and training you will provide to your providers to ensure continuation of services; and
- What information you will provide your members to assist with the transition of care
- Describe your approach to identifying "hot spotters" who are high utilizers and describe any innovative approaches you utilize to be able to identify the difficult to find patients. (5 points)

UnitedHealthcare's adoption of the Triple Aim of better health outcomes, improving the care experience and lower costs of care guides our commitment to person-centered care, which is essential to improving the health and wellbeing of individuals, families and communities. In this effort, we have implemented many managed Medicaid plans nationwide, including Bayou Health, and understand that the transition of required health care services must be consistently seamless to members. Our standard, scalable processes minimize interruption in required services during the transition. We have worked with many other states during contract renewals and procurements to transition members in and out of our health plan, ensuring continuity of care for the member. Moreover, we have worked closely with DHH for our existing Bayou Health contract to design the specifications and file layouts for acceptance and processing of historical data from the State for members who transition into UnitedHealthcare. In addition to leveraging the lessons learned and best practices from our Bayou Health experience and 22 other states across the country, we have established policies and procedures to identify members with special health care needs and make sure those members continue to receive medically necessary services. As described in this response, UnitedHealthcare will comply with continuity of care and care transition requirements as outlined in RFP Sections 6.29 through 6.36.

- We seek to enhance the performance of the health system and improve the overall health and well-being of the Bayou Health members we serve and their communities.
- We work with health care professionals and other key partners to expand access to quality health care so our members can get the care they need.
- We support the physician/patient relationship and empower people with the information, guidance and tools they need to make personal health choices and decisions.
- We strive to deliver consistent performance, solid fundamental execution and an innovative approach to health care.

Identification of Members with Special Health Care Needs

Upon receipt of historic claims data from DHH, we automatically upload it into Impact Pro, our predictive modeling tool, and the Strategic Management Analytic Reporting Tool (SMART) data warehouse, so that we can further analyze each member's needs. We employ various outreach and identification processes to ensure members receive ongoing services. While health risk assessments (HRAs), retrospective claims and authorization data are the first line of identifying new members receiving services, we have an extensive outreach program that supports identification, coordination and referral for continuing medically necessary services. We collaborate with relinquishing plans and Medicaid fee for service (FFS), members/families, community partner staff (program care managers and other health care program clinical and administrative staff) and fiduciary entities to identify members who are receiving authorized and community-based services. We supply information to assist members transitioning out of our plan to the receiving plans as well. In addition to claims and pharmacy data, we integrate authorization and pre-certification information into our identification stratification methodologies for members with special health care needs and others receiving ongoing services. For members transitioning to us from another plan or FFS program, we outreach to the relinquishing health plan and care manager for the member's medical authorizations records, plan of care and service authorizations to both identify members and to ensure current services are continued and transitioned without interruption. This includes information on members' hospital discharges and related labs and medications. We take added measures to ensure our members' needs are met during and after the transition period and strive to make sure their care is not disrupted in any way. We conduct outreach to new members and, when appropriate, conduct a face-to-face evaluation. Whenever possible, we take steps to maintain a continuous relationship between the member and his or her PCP, including a new contract with that PCP.

The following processes focus on identifying members with special health care needs, e.g., pregnant, ventilator dependent, members having targeted chronic conditions defined by contractual requirements:

- Analysis of historical data and risk stratification
- Review of inpatient and ER history, including discharge summaries from the Louisiana Health Information Exchange (LaHIE)
- Review of current medical and service authorizations
- Review of current prescriptions and lab results
- Review of diagnosis codes for completeness of medical interventions
- Review of gaps in care as determined by Impact Pro evidence-based interventions
- Review of information received during new member welcome calls and case management assessments
- Review of specialty or behavioral health referrals

Analysis of Historical Data and Risk Stratification

Retrospective claims data provided by DHH allows us to identify those members with complex needs and those who require assistance during a transition into our plan, including members with special health care needs. Claims data is used to:

- Identify individuals receiving ongoing critical services that would be at risk during transition
- Identify members who have received any behavioral health services through their PCP
- Identify members with frequent ER visits or admissions to acute settings
- Identify members with frequent skilled nursing facility to hospital readmissions
- Identify members with long facility length of stays
- Review complexity of diagnoses and medications
- Review specialty visits
- Understand, based upon claims, the provider care team of each member, including specialty, PCP(s) and hospitals

Once identified, these individuals can be prioritized for initial outreach and welcome calls to engage them in appropriate case management programs as early as possible.

Our SMART data warehouse allows us to store the historical claims files received and match that information to our ongoing claim experience to generate a more complete history of the member experience during the transition period.

We will ask for prior authorization and case management data from the relinquishing plans and will provide like-data for members transitioning from us to other Bayou Health plans. This includes service authorizations for members receiving home and community-based services (HCBS). This information ensures we provide ongoing medications, ambulatory care, inpatient services and other care.

We generate a list of service coordination reports targeting high-risk continuing services. Case managers use these service lists to reach out to existing and new providers through phone calls and letters to make sure a member's services are not interrupted. Case managers review patient rosters identified by provider and service type with individual providers and solicit additional information about members. Among other topics discussed, we review with those providers our plan for continuity of care and ensuring no interruption in medically necessary services for members with special health care needs.

From SMART, we load DHH's retrospective claims data and our current claims data with any newly gathered data into our episode-based predictive modeling tool, Impact Pro, which allows us to predict health risk for our members and to prospectively identify members with special health care needs who may benefit from care coordination, case management and the chronic care management programs (CCMP). Impact Pro, using evidence-based rules, identifies gaps in care for each member using compiled information from multiple sources, including claims, laboratory and pharmacy data. For purposes of transition, Impact Pro allows us to achieve two important goals:

- Identification of members who may benefit from ongoing case management and CCMP and stratify their risk, so that the most vulnerable can be targeted first
- Identification of gaps in care for each member based upon evidence-based guidelines

[redacted]

In combination with custom transition reports from our SMART warehouse, we flag members needing immediate service coordination by identifying members who are receiving recurring, ongoing services that require extra support during transition (e.g., hospice, home health care, dialysis, recurring durable medical equipment services).

New Member Welcome Call and Assessments

For members transitioning to UnitedHealthcare, their first experience with us may be during the new member welcome call. Our goal is to contact members early and often to establish relationships and assuage any concerns about the transition. Members new to our health plan or new to managed care often have a number of common questions the first month of enrollment, ranging from basic questions on benefit coverage to assistance with changing PCPs.

Our new member welcome team, comprised of member services representatives (MSRs), conducts outbound calls to new members. They are trained to understand and anticipate our new members' unique needs, e.g., need to transfer a prescription or authorization for a service they are currently receiving. MSRs use innovative tools and scripting to provide validated health plan information, to answer any immediate questions, to address any concerns our new members may have about access to care or health plan-related questions and to:

- Welcome the member and verify demographic information
- Offer an overview of the member's covered benefits and services
- Promote member engagement through motivational interviewing and gather timely information to help provide personalized services
- Confirm the member's PCP assignment, discuss the importance of the PCP/member relationship, address PCP-access issues and offer to help the member change his or her PCP, if necessary
- Conduct the HRA during the call to identify care or case management needs, offering to reschedule it for a time that is more convenient for the member, as necessary

- Refer members to care or case management for a comprehensive health status assessment (CHSA) based upon the HRA score
- Discuss the member's active treatment plan and receipt of any covered, medically necessary and authorized services
- Triage members to identify care or case management needs and the need for additional transitional support using an HRA
- Connect members with their PCPs by assisting with appointment scheduling and, as needed, secure transportation services for the PCP appointment
- Discuss the importance of EPSDT screenings with members or their families and assist members who need to complete EPSDT screenings that are due or overdue
- Promote value-added services and preventive care, e.g., well checkups and dental screenings
- Review how to access pregnancy programs and resources, e.g., referrals to Healthy First Steps, Text4Baby and Baby Blocks, as needed
- Review how to access carved-out services, e.g., specialty behavioral health services, dental services, personal care services, waiver services
- Document information in our clinical management system, CareOne, providing care coordinators and case managers with access to up-to-date, member-specific information to facilitate the coordination process
- Confirm the member has received written materials including their welcome packet
- Educate members about covered services complemented by various other communications methods, including:
  - *Member Handbook*
  - Member newsletters
  - Member Web portal
- Inform members that our public website (*uhccommunityplan.com*) is available in English and Spanish and that they have the option to print their own ID card and access their benefits and claims information via the link to the secure member website (*myuhc.com*)

We make three outbound call attempts at different times of day to maximize the number of members we reach. If necessary, we involve our Louisiana based community health workers to help us find and engage new members and to encourage them to contact us. We serve members in their choice of primary language, and many of our MSRs are bilingual. In addition, MSRs have access to interpretive services, which provide translators for more than 170 languages, as necessary. We make special arrangements for members who do not have a telephone or who have special needs and require a face-to-face meeting to complete assessments.

Assessments systematically drive identification of person-centered needs, goals and interventions to achieve best practices in chronic disease management.

Health Risk Assessment

Risk identification begins with an HRA, and we make it a priority to conduct an HRA for each member to align them with appropriate interventions and services, thus maximizing the impact of our case management and CCMP efforts. Our integrated HRA is an integral part of our member outreach efforts, inbound member and outbound calls, workflows and provider partnerships. The

HRA tool is algorithmically designed to assign population health stratification levels and used to prompt further discussion regarding a member's current and historic clinical, behavioral and socioeconomic needs so that we can align members with appropriate intervention approaches and maximize the impact of services provided.

The HRA reviews existing knowledge gaps and culturally sensitive insights that may influence health outcomes. In the event a member calls into member services and has not completed an HRA, the system will route the member, based upon stratification, to a qualified staff member to complete the HRA and address the member's reason for calling. The HRA data helps us identify members with risk factors that indicate the need for additional services, such as care coordination, case management or CCMP. Examples of risk factors include:

Health Risk Assessment
We conduct a telephonic HRA for new members. The HRA includes:

- Complete demographic information
- Emergency room utilization in the last year
- History of hospitalizations in the last year
- Presence of co-morbid chronic medical and behavioral health conditions
- Ability to perform activities of daily living
- Perceived risks
- Self-reported health status
- Strengths-based needs and preferences

- Members with special health needs, e.g., diabetes, HIV, Hepatitis C and sickle cell disease, cancer, stroke, transplant, spinal cord injury or serious behavioral health conditions
- Overutilization of services, e.g., multiple inpatient admissions or ER visits within the past six months
- Underutilization of services, e.g., members who do not have a PCP, have not visited their PCP within the past year or have gaps in preventive and diagnostic screenings
- Members with complex or co-morbid medical and behavioral health conditions

The HRA is an initial assessment tool used for new and existing members to identify a member's health risks. Based upon the member's response to a series of questions, the tool assigns a score that corresponds to a level.

Continuation of Services - Additional Information Requests for DHH

To better assist us in ensuring continuation of services for new members, we request DHH consider providing MCOs (or requiring other MCOs to provide) with the following member-related information:

- An identifier for the relinquishing MCO on the 834 enrollment file for all members transitioning from one MCO to another.
- Members with open authorizations and their authorizations, including inpatient and pharmacy.
- Members awaiting a transplant or who had a recent transplant.
- Members currently enrolled in any type of care/case management.
- Members who are pregnant.
- Member PCP listing.
- Members currently enrolled in chronic case management and their plans of care.

- Pharmacy claims history. If two years is not feasible, then at a minimum, we request six months of history, including any prior authorization that the FFS program granted. To facilitate transition, we request the data prior to the go-live date.
- Members for whom we do not have contact information.

In addition, a census for our new members hospitalized on the member's effective start date will allow us to begin appropriate discharge planning and to prevent any lapses in a member's care that might result in an unnecessary readmission.

In other states, we have worked collaboratively with other managed care plans to develop file formats to allow for the exchange of information directly between the plans. This has proven to be very effective. In addition to the claims data being provided by the State, we recommend DHH consider a similar data exchange solution. Our Chief Information Officer, Gabe Moreno, has experience with this and commits to partner with DHH and other plans on this effort.

Ensuring Continuation of Services

Key components of our plan to ensure continuation of services include:

Establish a Command Center and Dedicated Member Care Transition Team

For large-scale transitions, we establish a health plan command center, located and staffed locally, so that we can monitor day-to-day operations for a successful transition. A dedicated local team is prepared to help new members transition successfully to UnitedHealthcare. This member care transition team is an interdisciplinary team that monitors members for continuity of care and appropriate care. The team includes leaders from our clinical team (chief medical officer Dr. Ann Kay Logarbo and medical management manager Linda Rintala, RN), behavioral health (e.g., behavioral health medical director, Charles Freed, MD and behavioral health coordinators), member services, pharmacy and provider network areas. Another best practice includes implementing a governance process chaired by the State that includes a forum of all the state's managed care plans.

Our dedicated member care transition team manages the review of any available clinical data, transitional claims or authorization data for new members, monitors transition volumes and resolves any escalated issues. High priority Bayou Health population subsets include:

- Pregnant women, making sure they are quickly referred to Healthy First Steps
- Individuals with significant needs, including special health care needs or complex conditions
- Individuals receiving ongoing needs (e.g., maintenance medications) or services or those who are hospitalized at the time of transition
- Individuals who received prior authorization from the relinquishing MCO or FFS program
- Individuals with behavioral health and chemical dependency issues

For people in these subsets, their transition plan is tailored to their specific health care needs. We review any existing plans of care and create a new plan of care based upon the member's current needs. Our member services staff is well trained on the Louisiana community, the locations of local medical facilities and the cultural diversity of Louisiana, helping us to better assist our transitioning members. As necessary, they are informed about large-scale member transitions

and trained on the addition of any new covered benefits and services that we may offer as part of Bayou Health.

The member care transition team monitors our welcome strategy process, including use of the HRA, continuity of care and resolution of escalated issues. Prior to the transition period, the member care transition team may conduct daily team calls to monitor progress and to identify and expedite resolution of transition of care issues. These actions make certain individuals transitioning to us experience no disruption or delay in accessing their care and services. In addition to concerns about existing prior authorizations, any members new to managed care may have concerns about their assigned PCP or benefit coverage, and they may need immediate care or case management support for an ongoing condition

Our goal is to identify and mitigate transition issues prior to issues occurring. When issues do surface, our cross-functional team moves quickly to identify root causes and implement solutions. In many cases, issues are resolved within hours or days of being discovered. This solution demonstrates our commitment to resolving remaining issues as quickly as possible to meet the needs of DHH, our members and providers.

Coordinating Care with Other Health Plans

Collaboration and coordination are required when members transition between health plans. This approach benefits members by making sure medically necessary care is not disrupted during care transitions. Today, we coordinate services when members transition from one plan to another or when members are dually enrolled with us for medical and basic behavioral health services and the State Management Organization (SMO) for specialty behavioral health services. As a member of the Louisiana Association of Health Plans, we have formed collaborative relationships with other health plan peers as well as with providers and stakeholder agencies, including DHH, school-based health centers (SBHCs), federally qualified health centers (FQHCs), juvenile justice and others to effectively deliver and coordinate care.

Clinical Information Sharing

Collaboration between health plan managers occurs on a regular basis to share eligibility information or to facilitate member transition of care. A best practice we've instituted in other states during the initial implementation includes a daily check in call or meeting between clinical health plan managers. This level of collaboration and communication between plans minimizes any potential barriers that could arise when transitioning members between health plans or the State's FFS program. Our chief medical officer, Dr. Ann Kay Logarbo and medical management manager, Linda Rintala commits to collaborate in Louisiana in the same manner. When notified of transitioning cases, care managers outreach to providers to obtain clinical information and authorize ongoing care as needed to avoid disruption in a member's treatment. We have and will continue to focus on the needs of our members by working closely with relinquishing plans to identify special populations that require enhanced coordination. We use a formal fax document process to request information from other health plans.

In accordance with RFP Section 6.36 Care Transition, during the transition period, as the receiving MCO, we are responsible for, but not limited to, notification to the new PCP, if applicable, of the member's selection of provider, initiation of the request of transfer for the member's medical files (unless the member has already arranged for the transfer of his or her medical records), arrangement of medically necessary services (if applicable) and all other

requirements for new members. If we have not received the member's record within 10 business days of the request, we will follow up with the relinquishing plan to resolve the issue.

Using our Population Registry, clinical and claims data received from the relinquishing plan is made available to the PCP to facilitate continuity of care and continuation of medically necessary services. We are available to make direct in-person or telephonic contact with providers, as necessary, to facilitate the care transition process.

Coordinating Continuous Care

We coordinate continuous care as necessary for all members transitioning to UnitedHealthcare. We place special emphasis on coordinating care for individuals with complex and comorbid needs, particularly those with frequent exacerbation of chronic conditions that require high utilization of medical services, e.g., uncontrolled diabetes or asthma and behavioral health recovery services. We also provide additional support and care to members in the following subpopulations:

- Members with significant conditions or treatments, (e.g., chronic or complex conditions, external feedings, oxygen, wound care, ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized).
- Members who have received prior authorizations for services, such as scheduled surgeries, post-surgical follow up visits, therapies to be provided after transition or out-of network services.
- Members with special needs may also include members who have conditions requiring ongoing monitoring or screening, e.g., elevated blood lead levels and members who were in the NICU.
- We give special consideration to members with significant medical conditions, e.g., high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation and chronic illness resulting in hospitalization. We take steps to make sure these members do not experience a disruption or delay in accessing care and services in the new plan.
- When receiving a transitioning member with special health care needs, the care or case manager will coordinate with the relinquishing plan so that our new member's services are not interrupted and provide the new member with detailed plan and service information, emergency numbers and instructions on how to obtain services.

Prior Authorization Services Requirements

We work proactively to avoid disruptions related to prior authorizations (e.g., scheduled surgeries, post-surgical follow-up visits, therapies to be provided after transition or by out-of-area specialty providers). **We will honor all existing prior authorizations during the transition period as required for members including those with special health care needs, allowing time for appropriate review and coordination of care.** To accomplish a seamless transition, we use data to identify members impacted by the transition. This includes prior authorizations from out-of-network providers, in-network providers or for services that did not require a prior authorization in a fee-for-service program. Once we have complete information for a member, we make medically necessary determinations based on assessments, provider input, clinical records as well as input from the care management team and the

member/family/caregiver. Medical necessity determinations are made as fast as the member's condition requires and in accordance with contractual requirements.

We adhere to contract requirements for assuming responsibility for the costs of continuation of services provided by participating or non-participating providers. We offer contracts to non-contracted providers so that members who transfer into our plan can continue receiving services from the same provider. If providers do not wish to contract with us, services will continue with a contracted provider of the member's choice through the transition period. Any transition to a new PCP is carefully coordinated in a manner that ensures that there is not an interruption the in member's care and services. **During transition, we will not deny prior authorizations solely on the basis of the provider being an out-of-network provider.**

We agree to comply with the RFP requirements that clearly delineate financial responsibility for the provision of continuity of care to members during the transition period to our plan and beyond, including:

- ***Medically Necessary Services:*** We will not require service authorization for the continuation of medically necessary covered services for a new member transitioning into UnitedHealthcare, regardless of whether such services are provided by an in-network or out-of-network provider, however, we may require prior authorization of services beyond 30 calendar days.
- ***Hospitalized members:*** If the Bayou Health member is hospitalized at the time of transfer, the transfer is effective for the date of enrollment into our plan. However, the relinquishing plan is responsible for the member's hospitalization until the member is discharged. We are responsible for all other care.
- ***Pregnant women:*** We accept responsibility for, without any form of prior approval or without regard to services provided by network or non-network providers, continuity of care services as specified in Section 6.30, if the member is receiving services on the day before enrollment:
  - Costs of continuation of medically necessary services in addition to medically necessary prenatal care services
  - Members in second or third trimester will receive continued prenatal care and care for 60 days post-partum if they are still eligible for Medicaid
- ***Members with special health care needs:*** We are responsible for the cost of and continuation of medically necessary covered services, as specified in Section 6.32, if the member is receiving services on the day before enrollment:
  - Continuation and coordination of services up to 90 calendar days or until the member can be reasonably transferred without disruption, whichever is less.
  - After 30 calendar days, we may require prior authorization for continuation of services but may not deny authorization solely on the basis that the provider is a non-contracted provider.
- ***Pharmacy services:*** Per Section 6.33, we are responsible for the cost of and continuation of maintenance medications, including antidepressants and antipsychotics, for at least 60 days after launch of pharmacy services or member enrollment. In addition, the member may continue to receive a prescription drug that is not on our formulary for at least 60 days if he or she was receiving that drug at the time of enrollment. For medications

prescribed to members in a state mental health treatment facility, we are responsible for the cost of and continuation of this medication for at least 60 days after the facility discharges the member, unless it is deemed not medically necessary or potentially harmful to the member by our psychiatrist in consultation and agreement with the facility's prescribing physician.

- ***Behavioral health:*** Per Section 6.34, we are responsible for the cost of and continuation of basic behavioral health services and referral to the SMO for specialized behavioral health services.
- ***DME, prosthetics, orthotics and certain supplies:*** Per Section 6.35, for 90 calendar days after enrollment, we are responsible for the costs of and continuation of these supplies/services (without any form of prior approval and without regard to services being provided by a contract or non-contract provider) if the member was receiving them and had a prior authorization in place from the relinquishing MCO or FFS program on the day before MCO enrollment.

Use of Non-Contract Providers

If the member's PCP or specialist is not in our network, we make every reasonable attempt to contract with that provider. If the provider does not wish to contract with UnitedHealthcare, we will work with the member to choose another provider and transition the member to the preferred in-network provider; or, as necessary, we will work with the provider to establish a single-case agreement to provide services to this member for a specified payment rate. For example, we allow pregnant members in their second or third trimester to remain under the care of the current OB/GYN through the postpartum checkup (up to 60 days post-partum if they are still eligible for Medicaid), even if the provider is out of network. In addition, pregnant members in the first trimester will be allowed to continue to visit an out-of-network provider until we can reasonably transfer her to a network provider without interfering with service delivery.

As specified in the RFP, we reimburse a member's out-of-network providers for up to 30 days after a new member's effective enrollment date. In addition, for new members transitioning into UnitedHealthcare from another plan, we are responsible for the cost of and continuation of basic behavioral health services and for making referrals to the SMO for specialized behavioral health services.

Transportation

We will comply with Section 6.23 Medical Transportation. During the continuity of care process, through member contact, we gather information about barriers to care, including transportation. We assess a member's transportation needs during the assessment and care planning process and, if necessary, coordinate with our non-emergency medical transportation (NEMT) vendor to arrange for transportation to medically necessary services, even if they are provided by a carve-out provider or program. If, during the assessment, the member indicates an ongoing need for transportation to regularly scheduled appointments, member services staff, care coordinator, case manager or community health worker can coordinate that service with our NEMT vendor.

Information and Training for Providers to Ensure Continuation of Services

We offer focused training events and workshops through regional town halls that have been well attended and effective. We also perform individual office visits for training as needed. We supplement these visits with virtual provider trainings using conference calls assisted by Web-based training tools for practices with Internet access. We also have focused outreach with key

provider associations through in person meetings and partner with them to provide additional training events or to distribute written material. We set up standing meeting with the professional associations on an ongoing and regular basis to ensure that we get their feedback and can communicate through them to their large membership base. As matter of practice, we provide the key associations with all of our materials, including our more urgent blast faxes and eAlerts. To ensure continuation of services for our members, we provide the following information, education and training for providers:

- During transition periods of large groups of members, we:
  - Post information related to continuing medically necessary services during the transition period on our provider Web portal, BayouCloud, to make sure it is readily available to all Louisiana providers and their office staff.
  - Alert providers to the availability of support for continuity of services in the *Provider Administrative Guide*.
  - Send a letter to all providers during implementation, explaining our policies on ensuring continuation of medically necessary services and continuity care and any steps they will need to take to request prior authorization of services on behalf of members.
  - Assist high-volume practices in developing transition plans for members who may be in the hospital on the program effective date, working directly with provider staff, including their discharge planning teams, to identify affected members and immediately begin planning for each affected member's safe transition from inpatient care to their home or other treatment setting.
  - Contact key providers caring for members on our target service coordination list to make sure they understand our policies regarding continuation of medically necessary services and continuity of care.
  - Educate providers about our risk stratification model and what specific gaps in care are open for these members that require closure
  - Conduct targeted training for providers and their clinical and administrative staff through a variety of venues including:
    - In-person training via direct outreach and office visits by our network staff to high-volume providers or regional town hall meetings
    - Online training and resources via virtual town halls to accommodate those who cannot or choose not to travel
  - Engage professional provider and practice management associations and attend meetings. We provide the key associations with copies of our materials, including our more urgent blast faxes and eAlerts.
- We will incorporate transition and continuity of services as part of the new provider orientation and educate providers on continuation of medically necessary services and the process for requesting assistance from UnitedHealthcare.
- We hold targeted training for our staff who interface with providers to give them the information they need to inform and educate providers to ensure uninterrupted services:

- ***Provider Advocate Team:*** To deliver quality care to our members, our provider advocate team develops a close partnership with our network providers to address any issues they may have. During care transitions, the provider advocate team works closely with providers to explain processes related to waiving prior authorizations for members transitioning to us and offers support during the transition period. Provider advocates engage providers through regular meetings to discuss operational issues. Members of our health plan leadership team, such as Dr. Logarbo, chief operating officer, Mr. Lirette, director of network strategy, Ms. Tillman or Ms. Rintala, attend most of these meetings to discuss strategic initiatives.

  Our local provider advocates, Dana Fisher, Melissa Chambers and Tracey Guidroz, educate provider staff on many topics, including the importance of continuation of medically necessary services, how to use the information available in the Population Registry and how at access additional information on our portal. They are the frontline connection between our health plan and the provider.

- ***Clinical Practice Consultant (CPC) Team:*** In Louisiana, we have incorporated a variety of techniques to motivate and improve provider performance, quality of care and improve member adherence with well-care visits as a result of our profiling efforts. This includes using registered nurse CPCs to visit providers and share best practices and clinical tools that help providers identify areas for improvement. The CPC team is a critical component of provider education. Working with CPCs, providers can improve their understanding of best practices and provide improved member care. CPCs will reinforce the need for uninterrupted services for our members' ongoing needs, particularly for our most vulnerable members, including members with special needs.
- ***Community Health Workers:*** In addition to other responsibilities, community health workers distribute educational materials through community-based organizations and to the provider community.

- If a member's current provider is not participating in our network, we seek to bring them into the network. We educate new providers on pertinent topics, such as:
  - Issues related to provider agreements/contracts
  - Available assistance when transitioning to UnitedHealthcare as a new health plan partner
  - The prior authorization process and waived prior authorization period
  - How to access BayouCloud, walking providers through the process of how it works and where information is located
  - Overview of our population health, person-centered model of care
  - Case management program, how to make referrals to case management and CCMP programs and an overview of how case managers communicate with providers
  - Claims processing
  - Definitions of in-network, out-of-network, Accountable Care Communities (ACCs) and other pertinent terms
  - Cultural competency training

- Staff support available for ACC practices
- Provider profile reports
- Value-based contracting support, as applicable

Informing Members – Preparing Them for a Smooth Transition of Care

We look forward to supporting the health care needs of new members transitioning to UnitedHealthcare and helping them live healthier lives. We inform members about our health plan and what they can expect during the transition. We take the following actions to keep members informed during transition from start to finish:

- Welcome packet of information, including a letter educating members on what to expect directing them to look for their new health plan ID card, providing them with answers to frequently asked questions and the member call center phone number and member portal login instructions for access to the online portal
- New Member welcome call
- Member newsletters
- Transition of care information posted on our website and communicated during the welcome call, such as the continuance of prior authorizations for specified periods
- Ensuring the member has continuance of his or her existing PCP or mutual agreement on a new PCP
- Confirming the medical team, including specialists and service providers, that the member is using today
- Targeted communications to inform impacted members of specific changes
- Member town hall meetings and member orientation sessions at various locations across the service area for large groups of members transitioning into UnitedHealthcare
- Outreach to many community and faith-based organizations, partnering with them to educate members about the program and specifically about the transition of care
- Continuity of care information in the *Member Handbook*
- For members that we identify as requiring assistance with continuing medically necessary services, our case managers or community health workers can reach out directly and assist them, explaining the program requirements during face-to-face meetings, as needed
- Educate new members on how to access services, including the role of their PCP
- Promote use of community-based activities during welcome calls and ongoing by case managers and community health workers
- Work with DHH's enrollment broker to make sure information and materials, including UnitedHealthcare handouts about continuity of care, are available to members as they consider their options
- Educate our stakeholder partners, e.g., specialty behavioral health providers and personal care providers, about how members access services and how to contact the health plan as well as how to contact us about any members they serve who may need extra assistance during the transition

[redacted]

Our approach to identifying hot spotters who can benefit from our case management program includes:

- ***Impact Pro:*** Our proprietary predictive modeling tool compiles claims information from multiple sources, including laboratory and pharmacy data, to help us identify the top 5 percent of utilizers. Impact Pro uses a variety of evidence-based algorithms to identify members (hot spotters) who have a history of repeat hospital admissions, high utilization of medical outpatient services, potential quality of care issues or an indication of multiple providers of services that appear to lack coordination. Risk scoring and the stratification system within Impact Pro allow us to identify cohorts of members with multiple chronic medical and behavioral health conditions. Predictive models identify members who are at greatest risk for severe health care problems **in the future** and support case management by targeting the highest risk members and gaps in care. This tool is designed to recognize members with the full spectrum of diagnoses (e.g., diabetes, HIV/AIDS, depression, anxiety and others) and accounts for the acute and chronic conditions that contribute to a member's level of future risk. Generally, Impact Pro considers **three determinants of**

risk including predicted utilization, predicted costs and members who have not received appropriate care or followed recommended treatment programs.

- Case management staff evaluates Impact Pro information/reports and identifies members with the highest level of risk for further assessment. Impact Pro's automated algorithms forecast future health risk, stratify high-risk members and provide information for us to help build the intensity of case management interventions for our most vulnerable members.
- ***Enrollment File:*** The 834 enrollment file and two years of member-specific claims history provide valuable insight into member utilization, including use of carved-out services. This information is extremely important for the new opt-in populations—many of whom will need case management services. For example, we will place all members receiving personal care services in case management.
- ***Accountable Care Communities (Expanded Patient-Centered Medical Home) Model:*** As part of our population health, person-centered model of care, our Accountable Care Communities (ACC) model supports PCPs to have a leadership role on the member's care team, equipping them with valuable data from outside their practice and allowing them to quickly and proactively respond to high member utilization patterns. We encourage our members, especially our most vulnerable members (or identified hot spotters) to join an ACC, where staff coordinate care, make referrals to all covered and carved-out services, follow up with members and measure health outcomes. ACC providers have access to our Population Registry as well as our Automated Care Transitions tools, which are designed to share member-specific information electronically with the member's interdisciplinary care team. The Population Registry informs providers of critical real-time data. Community nurses work with practice staff providing training for Population Registry use and coordination activities for which the ACC practice is accountable. Our Population Registry provides real-time information and a comprehensive view of the services used by any given member population. A daily data feed of adverse events (hospital/ER) through the care transition software facilitates outreach to members, which is particularly important for members using the ER as a source of primary care. This information promotes timely follow up with providers post ER or inpatient discharge and ensures repatriation into the PCP's practice. Our community nurse shares these opportunities with ACC staff to inform and, as appropriate, amend plans of care. Impact Pro identifies risk for medical and behavioral needs, which helps ACCs identify care for members. If a member chooses not to join an ACC, we work with the member to select a PCP that meets his or her needs and encourage the member to establish and maintain a relationship with their selected PCP. In fact, all PCPs who have a panel size greater than 100 members will have access to our Population Registry and the supporting information contained therein.

> We currently have 56,574 Bayou Health members in ACCs.

Innovative Approaches to Locate and Engage Difficult-to-Find Members

Medicaid is an important safety net for our most vulnerable members. Yet, engaging members can be one of the most difficult tasks of the case management program, which is designed to address our members' complex physical and behavioral health issues. The combination of poor contact information, unstable housing, overwhelming socioeconomic challenges, and, in some

instances, lack of trust, can make finding and engaging members with chronic conditions and/or mental health and substance use conditions difficult. Therefore, we have made investments in creative and persistent approaches to locate and engage difficult-to-find members, including:

Making Neighborhood Connections through Community Health Workers

In Louisiana, our person-centered care model will increase use of feet-on-the street community health workers. We value the skills community health workers have in reaching members, establishing relationships, maintaining connections and linking members to services that optimize outcomes in the member's plan of care. As appropriate, we involve community health workers in targeted communities to help us locate and engage members so that we can close gaps in care and to encourage those members to contact us, to get preventive health care services and to participate in case management programs for which the member is eligible.

Community health workers collaborate with case managers and member services staff when locating and engaging difficult-to-find members—together they make up a member-finding team that is dedicated to persistent outreach and detective work, e.g., track pharmacy data to identify approximate refill dates and ask the pharmacy to notify us when the member is at the pharmacy. Through intensive feet-on-the-street efforts and leveraging their local knowledge of the community and follow up with community organizations, providers or community groups to get updated contact information for our members, community health workers often have success locating and engaging our members. In some instances when a community health worker locates a member, a case manager may conduct an in-person "drive by" to engage and educate high-risk members about the benefits of case management services and programs.

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Outreach to Homeless Members/Families

Individuals who are homeless are frequently our members who are most in need of services and are among the most difficult to locate and engage. Without adequate housing, they may find it difficult to self-manage their care. Member services staff, case management staff and community health workers collaborate regarding outreach activities to engage members in the assessment process to determine eligibility for care coordination, case management and chronic care management programs.

Similar to our approach in other states, we coordinate with local and state agencies to engage with members/families using shelters and specialized services. Community health workers contact providers who care for the needs of our homeless members to aid in the location and engagement of members. We recognize that some members do not have a stable address and may be intermittently homeless. We also know that some people do not have a cellphone or access to the Internet. For these members, we understand that we must use a number of approaches to reach them successfully. This includes:

- ***Working with Louisiana Department of Children & Family Services (DCFS):*** Community health workers begin the process of member engagement by working with DCFS to identify individuals who have had services provided previously in shelters or through street outreach.
- ***Teaming with Providers that Serve Homeless Individuals:*** Community health workers can actively work with our provider network to use their expertise, knowledge of the communities they serve and their understanding of individuals that may intermittently use their programs. Many of the providers in our network already work with members who are currently or formerly homeless and have a mental illness or substance abuse disorder. They have expertise in engaging homeless individuals and operate programs offering a variety

A study that included Louisiana to determine whether or not the engagement in the high-risk case management program had a significant impact on future admissions, emergency room visits and/or PCP utilization as compared to members who were not engaged in high risk case management was conducted (June to November 2012). Outcomes for members who were engaged in high-risk case management showed a 45 percent reduction in emergency room visits, an 11 percent increase in PCP utilization and a 19 percent reduction for members who had engaged in the program and had an indicator that their goals were met within 90 days of enrollment into high-risk case management program.

of services to specific populations. We also have contracts with FQHCs that provide services for those coming from the shelters and have close referral relationships with shelters. These types of providers have been strong partners as we seek to locate and engage members who are homeless or transitioning back to the community.

I.2 For members who need home health and/or other services upon discharge from an acute care hospital, explain how you will coordinate service planning and delivery among the hospital's discharge planner(s), your case manager(s), your disease management staff member(s), and the home health agency. Further, explain how you will monitor the post-discharge care of enrollees receiving home health services in remote areas. (5 points)

Coordinating Home Health Service Planning and Delivery Post Discharge

Chief medical officer Dr. Logarbo and medical management manager Linda Rintala, RN, oversee resource coordination and interventions to achieve consistent, high-quality activities and to keep our members in the most integrated, least restrictive setting, particularly members who have had a recent ER visit or inpatient stay and need our help to make a successful transition to home. Members moving between different health care settings are at risk of receiving fragmented and less than optimal care when transitions are poorly managed. Poorly managed discharges can lead to increased ER visits, hospital readmissions within 30 days, stress and the potential for poor quality care.

Conflicting messages between the health care team, confusing medication regimens and lack of follow-up care are associated with high rates of recidivism in high-risk, vulnerable populations. Therefore, we have adopted the Coleman Care Transition model, created our innovative care transition software, as described below, and established processes and procedures for following up with discharged members to meaningfully enhance the care transition process and to coordinate service planning and delivery among the hospital's discharge planner(s), our case manager, interdisciplinary care team members and the home health agency, which may include representation on the interdisciplinary care team. We will use our Automated Care Transitions (*UHCTransitions*) tool to electronically notify ACC practices and transitional care managers of discharges from inpatient or ER. We will leverage the use of real-time admit, discharge or transfer (ADT) data to trigger these electronically secure notifications.

Our comprehensive transition care management (TCM) program ensures members are effectively transitioned after an acute hospital stay. TCM involves discharge planning, outreach, education, member monitoring, case management and community health workers. Case managers and community health workers make sure our members receive the care and services, including home health services, they need following a hospitalization. For high-risk discharges from an inpatient (IP) setting, we will notify our Home Health agency to do a post-discharge visit and functional assessment as necessary to assess the risk of the patient for readmission and the safety of the discharge environment, including caregiver supports. This will include a medication review as well. Following the home visit, appropriate referrals will be made.

Transition Care Management

Our TCM program is based upon evidence-based transitions of care and follows the tenets of the Coleman Care Transition model, designed by Dr. Eric Coleman at the University of Colorado Health Sciences Center. The model is designed to encourage patients and their caregivers to assert a more active role during care transitions.

Our goal is to have greater than 65 percent of Post Hospital Assessments completed by the transition case manager within three business days after the member has been discharged from an inpatient facility. Louisiana Medicaid year-to-date (YTD) results have varied from 69.1 percent to 86.4 percent, **averaging 81.7 percent YTD, which is well above the target goal of 65 percent. In addition, our 2014 engagement rate is averaging 86.5 percent.**

[redacted]

Frequent interdisciplinary rounds are conducted between the inpatient care managers and Dr. Logarbo to identify our most vulnerable members who may need to be enrolled into case management programs or who may need to link to additional services, e.g., home health and/or specialty behavioral health services. By conducting rounds and early discharge planning, anticipating needed services for successful discharge, services, equipment and supplies are identified and arranged in time for discharge. Medication reconciliation, an important part of the discharge plan, is executed upon discharge and may require a home visit from a community health worker to reinforce the importance of adhering to medication regimens and making and attending follow-up appointments.

[redacted]

The case manager and/or community health worker collaborates with the member, family and interdisciplinary care team members, including home health agency staff. We work with PCPs during the member transition, keeping them informed of critical member information, simplifying authorizations and providing additional support, as needed to arrange for necessary home health services. The member's discharge plan of care is updated to reflect a need for home health services. Member-specific goals and interventions are developed, as a partnership, with the member or authorized caregiver taking the lead. The interventional components of TCM focus on the following conceptual areas:

- ***Medication self-management:*** Member is knowledgeable about medication, has access to medications and has a medication management system in place.
- ***Use of a dynamic person-centered plan of care:*** Interventions are customized to the member's needs. Member/family active engagement in the care planning process and sharing of the plan of care across providers and settings
- ***Primary care and specialist follow up:*** TCM schedules and ensures members attend follow-up visits with the PCP or specialist physician and is empowered to be an active participant in these interactions. The member may receive assistance from a TCM or community health worker who can help schedule the appointment and arrange transportation, if needed.

> When it is easier for members to get care, or even just information, when they need it, they are more likely to follow plans of care. This means better outcomes and lower total costs.

- ***Knowledge of Red Flags:*** Member is knowledgeable about indications that his or her condition is worsening and how to respond.
- ***Education:*** Member is educated on use of a personal health record to facilitate communication and ensure continuity of services and the plan of care across provider and settings.

Our staff uses Impact Pro patient risk scores and a post-hospital assessment tool, which is designed to capture information regarding post-hospitalization care (e.g., follow-up appointments, filling prescriptions, obtaining prescribed DME and appropriate follow-up with the member's PCP) to help determine the needs of the member. This tool makes sure we address individualized person-centered needs.

Home health service planning and delivery begins during the discharge planning process. We take the following steps to ensure coordination of home health needs:

- Case management staff and community health workers engage members and providers in the hospital to assess each member's needs and develop a plan to deliver a safe and successful transition between levels of care. If a case manager is not already assigned to the member, one is assigned to assist with transition from an acute setting to home.
- Using our clinical management platform, BayouCare, the case manager identifies a member's prior health care issues, the types of services the member has received in the past and any services received immediately prior to admission.
- We gather information about family and support systems from the member's plan of care and interactions with the family during the member's inpatient stay.

- Part of strong discharge planning includes the involvement of outpatient providers to ensure a smooth transition from an inpatient setting back to the community. Evidence of our commitment to actively assist providers in discharge planning for members following acute episodes of care is making sure members have follow-up visits with a PCP within seven days. [redacted]
- We update the member's plan of care to include all needed services, including home health care, and get necessary approval for service authorizations.
- The case manager gathers and documents additional information from the member's treating physician, hospital discharge staff and any additional providers and health care professionals working with the member. The case manager may participate in joint rounds and seek additional provider input at that time.
- When the member's providers and interdisciplinary care team agree on the timing and physical needs of the member for discharge, we facilitate communication of the member's clinical condition and treatment plan to the identified health home, durable medical equipment and specialty home care providers.

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Leveraging Louisiana Health Information Exchange

As of Aug. 21, 2014, we had a live data feed and began receiving admit, discharge or transfer (ADT) data from 44 hospitals participating with LaHIE for our members who visited the ER over the preceding 24 hours. [redacted] Notifications and alerts improve the timely flow of information so that providers and case managers can quickly and effectively address the health care needs of members transitioning from inpatient facilities to care in the next setting or community. Case managers will call frequent ER users within 48 hours of an ER event to determine why the member went to the ER, to inform the member of available, appropriate resources (e.g., urgent care or PCP availability) for the future, and to schedule a follow-up PCP appointment for continuation of care activities within seven days of an ER event.

In addition to data feeds from LaHIE, we receive direct data feeds from eight facilities across the State that are not currently sharing data with LaHIE.

[redacted]

[redacted]

I.3 Aside from transportation, what specific measures will you take to ensure that members in rural parishes, or other areas where access is an issue, are able to access specialty care? Describe any plans for using telemedicine to expand services. Also address specifically how will you ensure members with disabilities have access? (5 points)

Telehealth: Modernizing the Future of Health Care

For Louisianians in rural parishes or other areas where access is an issue, in-person physician specialty care visits are difficult as the demand for these services often outpaces supply. We understand rural access requirements and the unique challenges to access high-quality care in such regions. To address these growing challenges, we have been developing a telehealth portfolio (offering care that is no longer location specific), which is intended to match our member's diverse needs, increase access to health care, improve care outcomes and manage costs. We will work with DHH to expand access to specialty care as needed and to support telemedicine access to enhance access to specialty care and follow-up care for members in rural and under-served areas and to help us to monitor care for members in remote areas. We will synchronize our efforts with DHH's Bureau of Primary Care and Rural Health to ensure our efforts build upon access to specialty care and do not duplicate or conflict with existing initiatives within the State.

We bring innovation and creativity to network improvement by leading the way with new technology and new ideas to improve access to quality care for our members. We have experience with telehealth, e-Consults from PCPs to specialists (e.g., New Mexico project ECHO) and telepsychiatry in other markets, including extensive experience serving rural areas in multiple states, e.g., Arizona, Texas, Tennessee, New Mexico and Hawaii. We leverage technology to support and deliver access to primary and specialty care for our rural members, such as telemedicine, which gives members access to physicians and specialists when in-person visits are simply not possible. From this experience, we see the value of telemedicine for members in rural and frontier areas. We have the expertise to bring this innovative approach to providing improved access to care to Bayou Health members.

While our preferred strategy is to refer members to a contracted specialty provider that is qualified and available, we will work with DHH to allow non-face-to-face visits as we have done in other markets with other Medicaid agencies.

Innovative telehealth approaches to expand access to specialty care in Louisiana include:

- ***NowClinic:*** NowClinic® Online Care (NowClinic) is a 24-hour, seven days a week telemedicine solution focused on driving more appropriate access for acute care, and dependent upon how it is deployed with providers, potential access to chronic, behavioral and specialty care. This solution is in place in other markets, and the goal is to help improve overall cost and quality, promote the right level of care and subsequently impact the overall productivity for the member and provider. There are four main components:
  - ***Technology:*** online website that serves as the home for the service containing general information, access to an enrollment and consult area, also accessible through phone only or the NowClinic mobile application
  - ***Network:*** board certified, licensed in Louisiana, in-network, general practice providers (e.g., MD) who are specially trained to provide online care, available within 15 minutes
  - ***Data Source:*** consult record captures patient diagnosis, prescription, demographic information and email address.

  As an option, NowClinic leverages local provider groups or extenders (e.g., in Maryland and Pennsylvania) to deliver care and can consider additional ways to operationalize the technology in different locations (e.g., on-site clinics, community centers)

  Major benefits include:
  - Potential cost savings, offering less costly alternative to traditional in-person visits in the ER, urgent care or office visit
  - Quality and reach, overcoming barriers of access
  - Opportunities to further extend provider reach and coordination between providers and specialty providers to address gaps in care and wellness opportunities

Now clinic is:
- Simple – One-click online access to health care providers
- Fast – Instant, live interaction (using video, chat and phone
- Accessible – Log on anytime, from anywhere to visit with a choice of providers
- Trusted – United credentialed, hand-selected providers, delivering quality care

- Seamless care coordination, tying this service to other health plan services (e.g., NurseLine, case management) and educating and referring to NowClinic as an available option

NowClinic proven results include:

- Lowering the cost for acute care treatment, e.g., $112.01 average cost savings per NowClinic consult
- Driving more appropriate access and reduction of ER/urgent care visits, e.g., 84 percent of members would have visited the ER, urgent care, provider office or retail clinics if NowClinic was not available
- Providing the same quality of care as an in-person visit, e.g., NowClinic has a lower follow-up rate than in-person visits and provider satisfaction is at 94 percent

- [redacted]
- ***NurseLine:*** Several initiatives are in place to increase NurseLine utilization. Clinical practice consultants, member services, outreach and marketing teams distribute NurseLine contact information at every opportunity. All members receiving care management services are reminded about the NurseLine number to use as often as needed. NurseLine staff is focused on answering calls on a timely basis to ensure the members are directed to the appropriate care level. During 2012, the NurseLine call abandonment rate for the utilization management line was only 1.98 percent. Key NurseLine indicators include the following (based on an internal pilot study):
  - ***Appropriate Care.*** More than 50 percent of care recommendations were different from caller's original intent, and 70 percent of callers who initially intended to use the ER were able to avoid an unnecessary ER visit.
  - ***Physician Referral.*** More than 10 percent of NurseLine callers are referred to a provider and receive appointment scheduling services.
  - ***Program Referral.*** 31 percent of callers are referred to a relevant health or wellness program.

  NurseLine achieves these bottom-line results while maintaining a customer satisfaction level of 94 percent.
- [redacted]
- ***Pharmacy Kiosks:*** Many local pharmacies in rural areas have self-serve kiosks where members can get updated biometric screenings, e.g., check blood pressure, without an appointment.

- ***Safety Net Providers:*** We identify and contract with rural safety net providers, including FQHCs, SBHCs, RHCs and other significant traditional providers (STP). For rural areas, we strive to meet all State access requirements. On an ongoing basis, we monitor/enhance network access and adequacy through network assessments and claims reviews.
- ***Out of network Providers:*** When developing the network in rural areas where there may be a lack of providers, we target the available network within the service area, which may include adjoining states or counties. As a short-term solution, we may authorize access to a non-network provider or an out-of-state provider, if a contracted provider is not available. In addition, we are open to facilitating a visiting specialist model as we have done in other markets and engaging those resources to increase access to specialty care.

Access to Specialty Care for Members with Disabilities

Individuals with disabilities are considered "individuals with special needs" according to DHH definitions and are included in our case management program. As part of the care planning process, the case manager works with member/family and provider(s) to identify any barriers to accessing specialty care. Case managers receive training and expertise to ensure members with special needs have access to specialty care. If the member has a disability that is limiting access or a unique situation arises, the case manager and the community health worker strategize with the member and provider to address the barrier and facilitate routine care and monitoring for the member, e.g., arrange transportation or an out-of-network provider.

Specialty care is any health care delivered by someone who specializes in one type of disease, part of the body or condition, rather than a PCP or general practitioner. Specialty care includes doctors who:

- Treat one kind of illness, like cancer or HIV/AIDS.
- Treat one part of the body, like eye doctors and neurologists (brain and nervous system specialists).
- Use one method of treatment, like surgeons or radiologists (who use radiation).
- Treat one kind of patient, like gynecologists (women), gerontologists (elderly) or pediatricians (children).
- Specialists who are not physicians can also be considered specialty care providers, like physical therapists. Groups of specialists may work together, at institutions like Multiple Sclerosis Centers of Excellence.

The member's PCP is responsible for determining what kind of specialist, if any, is needed for a member's condition at any given time. However, for some members with disabilities or chronic illnesses, e.g., cancer, HIV/AIDS or kidney disease requiring ongoing dialysis, the best person to serve as the member's PCP may be a specialist. If our member has a disabling, degenerative or life-threatening condition that needs ongoing specialized medical care, we allow members to see a specialist as their PCP.

Network Adequacy: We take steps to ensure network adequacy. Members have a right to a health care provider with appropriate training and experience, even if it means that we must find the member a provider outside of our network. If no one in our network has the right training and experience for a member's particular health needs, we will give the member a referral to an appropriate provider outside of our health plan. We will consult with that provider in developing a treatment plan. To access an out-of-network doctor:

- The member's PCP requests an out-of-network doctor.
- We must approve the request.
- Together with the member's PCP and the out-of-network doctor, we must agree on the member's treatment plan.
- We maintain the right to ask to redirect a request for a specialty provider to a practice within our network for comparable services.
- Case managers or community health workers may be involved in setting up arrangements and making sure appointments are made and kept.

Physical Access: In addition to ensuring network adequacy, we ensure provider compliance with the American's with Disabilities Act (ADA) related to access to facilities and offices. Providers must attest to compliance with ADA. We conduct onsite visits to a provider office to determine compliance with standards for physical accessibility, physical appearance of the office environment, adequacy of waiting and examining rooms, adequacy of medical recordkeeping practices, appointment availability and office operations.

We require providers to complete an assessment upon enrollment to identify any specialized services they offer so that we can understand the range of providers who are capable of meeting the needs of our members with specialized service needs, for example, providers may have specially trained staff, accessible durable medical equipment (DME), such as wheelchair accessible dental chairs, mammography or other unique capabilities, to serve members with specialized service needs. We capture and make this information readily accessible to our member call center and care management representatives to facilitate specialized service needs for members who need them.

During weekly interdisciplinary rounds involving chief medical officer Dr. Logarbo, interim behavioral health medical director, Dr. Freed, Ms. Rintala, Dr. Ordoyne, our inpatient medical director, behavioral health coordinators and specialists, pharmacists and the case management team, we address specific specialty access needs for our members. We also hold ad hoc conferences, as needed.

Section J: Coordination of Carved Out Services

UnitedHealthcare has extensive local and national experience coordinating carved-out services provided for our members by other health plans and fee-for-service (FFS) programs. Carved-out services in Louisiana include Medicaid services reimbursed and provided through the DHH FFS programs, such as specialty behavioral health, dental, personal care services (PCS), targeted case management for members with special health care needs and other waiver-specific services, including long-term services and supports (LTSS). Currently, we successfully coordinate with the Louisiana Behavioral Health Partnership (LBHP) State Management Organization (SMO) to manage our Bayou Health members who are in need of specialty behavioral health services, with the State's Medicaid dental benefits manager for members requiring dental care and with other entities as identified for other services. We agree to comply with each specification and requirement outlined in RFP sections 6.4, 6.34 and 6.37.

In 21 of the 23 states where we serve Medicaid and CHIP programs, we coordinate carved-out services, including Louisiana. Today, we work collaboratively with Louisiana Behavioral Health Partnership State Management Organization to coordinate services for our shared members.

Overall Approach to Coordinating Carved-Out Services

Care coordinators and case managers retain primary responsibility for coordinating all care for their Bayou Health members, including all carved-out services and work closely with staff from carved-out entities to coordinate services, avoiding duplication of services and ensuring member care. We define and disseminate to care coordinators, case managers and PCPs the policies, procedures and criteria for making referrals to and coordinating care with specialty behavioral health providers, the State's dental management program and community agencies providing other services such as PCS. These policies and procedures specifically address members with co-occurring medical and behavioral health conditions—this includes children with special health care needs who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services. To assure appropriate care, care coordinators, case managers and PCPs may refer members to the appropriate health care specialist, (e.g., dentist or behavioral health specialist), as deemed necessary for needed services, regardless of whether services are covered or not covered under our Bayou Health program.

J.1 Describe how you will coordinate with the Louisiana Behavioral Health Partnership (LBHP) State Management Organization (SMO) for the management of shared members, including processes for reciprocal referral for needed services and prescription management (including but not limited to Sections 6.4, 6.34, 6.37 of the RFP).

Include how you will engage and educate primary care providers in their role in the provision of basic behavioral services and the coordination of co-existing conditions.

Include a description of the role Medical Director for Behavioral Health will play in these efforts. (15 points)

Behavioral Health Services

Bayou Health behavioral health services are divided into basic and specialized services as defined in RFP section 6.4.1. We establish and maintain formal policies and procedures to coordinate the delivery of core benefits and services, including the provision of basic behavioral health services. In addition, we:

- Assist PCPs, SMO staff and members with coordinating specialty behavioral health referrals
- Collaborate with interdisciplinary care teams (ICT) which may include PCPs, SMO staff and SMO specialty behavioral health providers
- Educate providers and members about the coverage, provision of and availability of basic behavioral health services and specialty behavioral health services
- Monitor care and health outcomes.

Having local and nationwide experience coordinating with carved-out behavioral systems, we have a clear understanding of how a behavioral health issue can interfere with a member's ability to access routine care for co-occurring, comorbid medical conditions, particularly those conditions that are of special interest to Louisiana, including diabetes, pregnancy, HIV/AIDS, sickle cell disease and Hepatitis C. This is why we include behavioral health conditions in our disease/condition hierarchy and why we currently have three behavioral health coordinators on our local staff to help coordinate integrated care for members.

Our behavioral health coordinators work directly with members, our case management team and the SMO by serving as an essential link between our members and their health care providers. They facilitate collaboration of medical, behavioral health and substance abuse care resources, escalating members to the SMO as necessary. They work directly with case managers, members, and network and non-network providers to make referrals for specialty behavioral health services and closely monitor interventions and services for members receiving specialty behavioral health care and "close out" referrals, as appropriate.

Figure 9. Behavioral Health Coordinators. We currently have three locally based behavioral health coordinators who work directly with members, our case management team and the SMO.

Specialized Behavioral Health - Coordinating with the State Management Organization

We acknowledge the SMO covers specialized behavioral health services as defined in the Medicaid State Plan. These services include those provided by psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental health clinics, mental health rehabilitation service providers (public or private) and other specialty behavioral health providers.

Joint Clinical Rounds with SMO Staff

We hold weekly integrated medical and behavioral health rounds, which include participation from Dr. Logarbo and Ms. Rintala, our manager of Healthy First Steps, case management, behavioral health coordinators, our utilization manager if needed, the SMO's chief medical officer and other clinical representation from the SMO. An average of 10 cases is presented weekly during joint rounds, inclusive of referrals to and from UnitedHealthcare and the SMO. In the new contract, our new BH medical director will attend rounds.

While specialized behavioral health services and payment may be carved out, members never are. Today, we coordinate and support basic behavioral health services provided by PCPs and refer members with specialized or more significant behavioral health problems to the SMO. We document referrals to the SMO in the member's plan of care and update the member's person-centered goals, as necessary, to include goals related to achieving improving behavioral health outcomes.

We will continue to collaborate with SMO specialty behavioral health providers to manage our mutual members who are receiving specialized behavioral health services to ensure that the full range of medically necessary and integrated services are provided to members. We currently have a memorandum of understanding with the SMO, formalizing our relationship and thereby promoting the integration of physical and specialty behavioral health services, allowing for appropriate continuity of care across the continuum of care and programs. We will maintain the MOU with the new contract.

Chief medical officer Dr. Ann Kay Logarbo and medical management manager Linda Rintala, RN, will work closely with our new interim behavioral health medical director, Dr. Charles Freed, continuing to oversee the effective coordination of basic and specialized behavioral health services, including referral management. Together they will make sure we comply with all behavioral health-related requirements in RFP sections 6.4, 6.34 and 6.37. Our clinical leadership team will participate in collaborative meetings with the SMO and DHH staff to facilitate and enhance medical and behavioral coordination as well as improve communication and share ideas and information. Inpatient hospital services for acute medical detoxification based upon medical necessity are considered medical rather than specialized behavioral health, and we will continue to cover and coordinate services for members who need care related to substance use accordingly.

Details of our collaborative relationship working with the SMO include:

Specialty Behavioral Health Referrals: We provide training for network providers and case managers on identification and screening of behavioral health conditions and SMO referral procedures. PCPs have an essential role in care coordination processes for members receiving specialty behavioral health care and services. PCPs work closely with members, community health workers, behavioral health coordinators and case managers to coordinate a member's care and make referrals to the SMO for specialty behavioral health care. As needed, case managers coordinate and support specialty behavioral health services by referring members with specialized or more significant behavioral health problems to the SMO.

Behavioral Health Summits and Other Joint Meetings

We regularly attend behavioral health summits with the SMO along with other health plan staff and providers. We regularly hold meetings with FQHCs to assure coordination of services between medical services and basic and specialty behavioral health services.

Our care coordination and case management policies and procedures define activities and staff responsibilities to support increased outreach and care coordination of medical treatment when an individual also has a serious behavioral health condition. In Louisiana, our three locally based behavioral health coordinators collaborate with case managers. They adhere to established policies and procedures when they coordinate care for members; work with network and non-network providers; make referrals; follow up with members, providers and SMO staff; monitor a member's interventions and specialty behavioral health care; and "close out" referrals, as appropriate.

Community Health Workers: Community health workers are an important part of our person-centered model. They work closely with our care coordination and case management staff to provide member education and assistance in accessing all needed services. This ensures timely access to providers and helps our members navigate the health care delivery system, whether services are covered or not or whether needed services are provided by the member's PCP or provided by a specialty provider from another health plan.

Using their knowledge of local resources and Healthify, our database of community resources, community health workers and MSRs link our members to available community resources specific to a member's needs, working face-to-face in the local community or telephonically with our members. Non-nurse staff members, e.g., community health workers, provide health coaching and educational materials and assist members with removing barriers to accessing care.

SMO Interdisciplinary Care Team Participation: For members in case management, the case manager forms a member-specific interdisciplinary care team for clinical consultation from PCPs, social workers, behavioral health specialists, private duty nurses or personal care service providers, other providers, dentists and pharmacists to link members to necessary services and verify coordination occurs following referrals. If the case manager has already established an interdisciplinary care team for the member but specialty behavioral health services were not part of the member's treatment plan, the case manager adds our behavioral health coordinator, the member's SMO case manager and, as needed, behavioral health specialty providers to the interdisciplinary care team.

We share the assessments, the plan of care and monitoring information (with the member's consent and in accordance with all state and federal requirements) among the interdisciplinary care team participants, regardless of network status. Using the Population Registry, our network providers have quick access to a member's claim and utilization data. We will also use our collaborative care tool within BayouCare, our secure provider portal that has the ability to share a common plan of care with the entire care team.

Behavioral Health Information Sharing: We will use BayouCare to share care plans and clinical information with SMO staff so that they can review cases real time on members, along with members assigned to behavioral health clinics. We successfully implemented this process with CenterStone, a community mental health center (CMHC), in Tennessee. In addition we regularly share information with SMO staff:

- During our weekly joint rounds that may also include SMO staff and behavioral health specialty providers
- During day-to-day interaction between our case managers, behavioral health coordinators and the SMO case manager

- Using agreed upon methods to exchange member-specific clinical information

Face-to-Face Visits: Our integrated, person-centered clinical operating model calls for identification of the need for face-to-face visits to assist members with self-management education or in overcoming barriers to accessing care. Face-to-face outreach may be provided by a community health worker or by a case manager with behavioral health experience, as a member's condition requires.

Joint Case Rounds: The case manager invites the behavioral health coordinator, SMO case management staff and the specialty behavioral health provider to provide input on the plan of care, participate in joint case rounds, consult on medication management and offer strategies for promoting member engagement in care and positive behaviors. Our behavioral health medical director will participate in joint case rounds.

Behavioral Health Advisory Committee: We will form a Behavioral Health Advisory Committee, led by our behavioral health medical director, Dr. Charles Freed, comprising Bayou Health members and health plan leaders, including Dr. Logarbo and Ms. Rintala, who will provide valuable input and insight into our member's needs and concerns. In addition, we recommend the formation of a behavioral health-focused joint operating committee with the SMO for ongoing discussions of joint initiatives.

Emergent Behavioral Health Care: If a member/family calls our toll-free member services center, NurseLine, care coordinator, case manager, behavioral health coordinator or any other UnitedHealthcare staff with an emergent need for specialized behavioral health services, our staff instructs the member to seek help from the nearest emergency medical provider. In addition, the referral is entered into our clinical management system, CareOne, which generates a reminder for the care coordinator or case manager to outreach to and follow up with the member within 48 hours.

The care coordinator will contact the member make sure he or she accessed appropriate services and offer to provide assistance in scheduling follow up appointments and transportation to a specialty behavioral health provider, as needed. In this instance, UnitedHealthcare covers payment for the emergency service, and the SMO covers payment for follow-up care by a behavioral health specialty provider.

Clinical Information Exchange: Our predictive modeling system, Impact Pro, synthesizes member data (e.g., diagnoses, hospitalizations, ER encounters, expenditures and demographics) and develops individualized risk profiles. To generate the most comprehensive results on an ongoing basis, we incorporate any monthly claims/encounter data and authorization data (including information from the SMO if we receive it). To ensure we have the information we need to coordinate services effectively for our members receiving specialty behavioral health services, we plan to work with DHH and the SMO to improve information sharing by encouraging the SMO to provide behavioral health specialty claims data to UnitedHealthcare for our shared members.

The following member story illustrates how we collaborate with SMO staff to help our shared members meet person-centered goals, remain in the least restrictive setting and achieve positive integrated health outcomes.

Medical/Behavioral Health Collaboration with the SMO

In 2014, our Bayou Health member "Sally" reached a low point in her medical and behavioral health, largely from self-neglect. Sally was concerned she would not be able to continue to live independently. Sally's medical history included alcohol abuse (since early adulthood), depression, hypertension, hypothyroidism and cardiac issues. Sally was hospitalized in April 2014 due to dehydration, hypernatremia and suspected seizure activity. This hospitalization was followed by two psychiatric admissions related to her alcohol addiction and depression. Through the discharge management process, we connected Sally to a PCP and the SMO who assigned a psychiatric nurse practitioner for follow-up care. To assist Sally, our case manager with behavioral health expertise convened an interdisciplinary care team that included a behavioral health coordinator, Sally's SMO case manager and representation from Adult Protective Services to help ensure the Sally's safety and to link her to additional providers to increase the intensity of needed services. With support, Sally was approved for waiver services and 18 hours of PCS per week. Sally is currently receiving assertive community treatment (ACT) services, which includes close monitoring by a psychiatrist and six home visits per month by a mental health professional who provides individual therapy and support and who also assists Sally with setting and achieving her personal goals.

We recognize it is imperative that UnitedHealthcare and the SMO collaborate to ensure efficient, non-duplicative integration of physical and behavioral health benefits for improved member outcomes. Over the course of our existing Bayou Health contract, our medical management team has worked to expand our partnership with the SMO with a focus on:

- Developing strategies to educate members on available services and how to obtain them
- Developing strategies to encourage communication including facilitation of appropriate transfer of medical records, ongoing coordination between physical and behavioral health providers, and reciprocal referrals between our network providers and SMO providers
- Developing and enhancing training of each other's staff on the collaboration process and available community resources
- Identifying and jointly working with community organizations and State agencies that can assist with collaborative efforts

Reciprocal Referrals for Medical and Behavioral Services Enhance Health Outcomes

Under the leadership of our behavioral health medical director, Dr. Freed, our case managers and behavioral health coordinators will serve as an important link between UnitedHealthcare and SMO staff. We encourage reciprocal referrals where we refer members to the SMO and/or specialty behavioral health providers based upon health assessments or as identified by the PCP or other inpatient/outpatient case management staff. We also solicit referrals from SMO staff on our members for medical services as identified by a specialty behavioral health provider or upon recommendations from SMO case management staff.

We have existing criteria and established processes for reciprocal referrals between UnitedHealthcare and the SMO, including cross training of respective staffs on referral processes. We anticipate enhancing reciprocal referral processes with our behavioral health medical director. Currently, case managers and behavioral health coordinators collaborate with the SMO to:

- Maintain and update formal procedures for reciprocal referrals
- Assist PCPs and the SMO in making appropriate referrals

- Define case management roles and collaboration following inpatient behavioral health treatment
- Establish communication and coordination protocols
- Address member concerns regarding access to specialty behavioral health care appointments and remove any barriers
- Attend weekly joint rounds with SMO staff

The following member story illustrates a situation where a specialty behavioral health provider identified a significant physical health issue affecting the member's quality of life.

Collaboration and Reciprocal Referrals Achieve Positive Health Outcomes

In summer 2013 in Vermillion, the family of a 14-year-old female member "Denise" who had a history of seizures and dyslexia, mood and behavior changes requested our assistance with locating mental health providers. The member was referred to the SMO by our behavioral health coordinator, Holly, and was evaluated and diagnosed with bipolar disorder, obsessive compulsive disorder and ADHD. Denise was subsequently admitted for four inpatient admissions over a 6-month period. During Denise's fourth inpatient admission at Acadian Care, Holly, received verbal permission to call our SMO liaison and assist them with coordinating Denise to specialty behavioral health and wraparound services. Holly referred Denise's mother to the National Alliance on Mental Illness (NAMI) for support. Holly worked with the family during Denise's four subsequent hospitalizations and a stay in juvenile detention for explosive, dangerous behaviors.

In October 2013, the SMO placed Denise in residential care. In November, Denise's mother reported to Holly that Denise had neuropsychological testing done at the residential facility and was diagnosed with a neurological disorder, which meant Denise's behaviors were in response to seizures in three different parts of her brain. Upon receiving a reciprocal medical referral from the SMO, Holly connected Denise to an outpatient adolescent/pediatric neurologist and a new pediatrician. Upon release from residential care, the SMO connected Denise to outpatient behavioral health specialty providers and provided this information to Holly. Denise was hospitalized a final time for dangerous behaviors and her mother reported she had been non-compliant with her medications. Holly worked with the mother and encouraged her to consider mental health counseling to help Denise develop age-appropriate coping skills and manage her symptoms. Denise's mother agreed and once engaged with a counselor, Denise adhered to her medications, ceased acting out and her mood stabilized significantly. In March 2014, Denise's mother reported to Holly that Denise went seven weeks without an incident. During interaction with the SMO liaison, we learned that Denise continues to adhere to her medication regimen and therapy and has developed better coping skills. Denise improved her grades and her relationships with family and friends. Denise has subsequently won recognition and several awards for her altruistic and charitable efforts in her local community.

Prescription Management for Specialty Behavioral Health Conditions

While pharmacy will be carved in, specialty pharmacy medications are the SMO's responsibility. During joint rounds or during other interaction with SMO staff, our case managers and behavioral health coordinators:

- Request details on SMO specialty behavioral health provider-prescribed medications so that we can document this information in the member's plan of care and assist them to overcome any barriers in getting or taking prescription medications.
- Review Impact Pro predictive modeling claims data and pharmacy reports.

- Conduct activities related to medication adherence and outreach, making sure our members have a system in place to help support their use of medications as prescribed from network and non-network providers, requesting assistance from community health workers to support members with barriers to accessing care and working with the member to identify solutions (e.g., pharmacy auto-refills, using a reminder system or organizing medication by daily doses).

Engage and Educate PCPs on the Provision of Behavioral Health Services

All of our population health programs revolve around person-centered care. The foundation of our integrated clinical model is built upon the core belief that individuals with behavioral health conditions can and do get better, they do recover and they do become more resilient to future challenges through their recovery. Our interactions with members and their families as well as our *Provider Administrative Guide* and provider trainings focus on this common understanding and common goal of recovery and resiliency.

We acknowledge the majority (at least 70 percent) but not all of behavioral health treatment can be and often is provided in a PCP setting. UnitedHealthcare is responsible for the management and provision of all basic behavioral health services for our members with mild or moderate depression, attention deficit hyperactivity disorder (ADHD), generalized anxiety, etc., which can be appropriately screened, diagnosed and treated in a primary care setting. We cover the following basic behavioral health-related services:

- Screening
- Prevention
- Early intervention
- Medication management
- Treatment and referral services provided in a primary care setting and as defined in the Medicaid State Plan
- Behavioral health-related ER visits
- Inpatient behavioral health-related detox

We have a variety of behavioral health screening tools for use by our clinical and non-clinical staff to assist in identifying members with potential behavioral health conditions including substance abuse issues. These tools are a part of our integrated care management clinical system platform and will be enhanced for online use prior to the 2015 Louisiana implementation date:

- Patient Health Questionnaire (PHQ)-2 and PHQ-9 screening for depression
- CAGE-AID and Tolerance (substance abuse screening tool), Worry, Eye-Opener, Amnesia, Cut-Down (TWEAK) screenings for substance abuse
- PC-PTSD screening for posttraumatic stress disorder
- DV-BIC screening for traumatic brain injury (TBI); GAD-7 for anxiety
- CSHCN screener for children with special health care needs.

Criteria for screening protocols and determining whether an individual meets the criteria for specialized behavioral health services may be determined by DHH and are based upon factors related to age, diagnosis, disability (acuity) and duration of the mental illness or behavioral health condition.

Under the leadership of our behavioral health medical director, we will ensure network providers use behavioral health screening tools and protocols consistent with industry standards and support PCPs by providing clinical practice guidelines for detection and treatment of common behavioral health disorders and by supplying behavioral health-focused practice management toolkits. We provide education, training and consultation to PCPs to support the provision of basic behavioral health services in a primary care setting and how to refer members to specialty behavioral health care. We provide this training through initial provider orientation and ongoing provider trainings, provider newsletters, the *Provider Administrative Guide*, webinars and group trainings, which includes offering them information on behavioral health topics (such as, motivational interviewing, brief solution-focused interventions and cognitive behavioral strategies) and supporting member materials they can distribute during office visits. We provide PCPs with copies of the member's plan of care, which can later be used to facilitate discussions with the member's specialty behavioral health provider.

To deliver quality and cost-effective behavioral health care to our members, we must identify emerging health care conditions as early as possible in the course of their evolution. It is, therefore, imperative that screening and referral to treatment of medical, behavioral and comorbid illnesses take place timely to effect prevention of further disability. This is also a core objective of the EPSDT screening process and why we routinely monitor provider medical records for completion of EPSDT screening activities specified in RFP Section 6.4.3. We provide and arrange for training for care coordinators, case managers, member services advocates and providers on identification and screening of behavioral health conditions and subsequent referral procedures. Healthy First Steps nurses screen pregnant women for substance abuse during prenatal and postpartum periods using the TWEAK five-question alcohol screening test. Members are also screened for possible use of substances during welcome calls. New moms are screened for postpartum depression.

Educational Materials for the Provision of Basic Behavioral Health Care Services

Without education and training, PCPs may miss the presence of behavioral health problems in their patients. With training, PCPs can deliver effective treatment for depressive disorders, anxiety or ADHD and improve member health outcomes by following evidence-based clinical guidelines, learning how to identify behavioral health issues, monitoring behavioral health outcomes and coordinating treatments more closely with behavioral health specialists in support of integrated member management.

We develop education materials for network providers on behavioral health resources. Educational and training topics may include:

- How to integrate medical and behavioral health services for special populations, e.g., pregnancy.
- How to identify members who need behavioral health services and where services should be delivered, screening processes, and diagnostic and monitoring tools routinely used in primary care practices.
- How to screen for and identify behavioral health disorders, how to refer members for specialty behavioral health services, quality initiatives and best practices for coordination and treatment.

- How to engage members to participate actively in their own care, i.e., how to use motivational interviewing techniques and communication techniques that facilitate informed decision making while encouraging member participation in treatment plans, care planning and self-management.
- Methods to deliver psychosocial interventions.
- Effective use of the Population Registry and BayouCare platform.
- Training on Wellness Recovery Action Plan (WRAP) facilitation to increase the number of members who use WRAP as a whole health wellness tool. We facilitate the development of WRAP in partnership with peers and other natural supports as needed. Through our health and wellness content, members access the WRAP application to identify mental health triggers, create a wellness toolbox, learn how to cope with symptoms and create a plan if symptoms escalate.

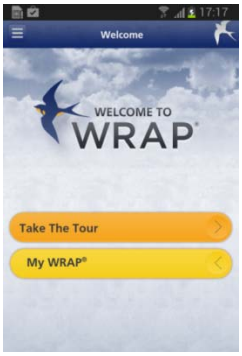


Figure 10. WRAP is a whole health wellness tool

- **Mental Health First Aid** is an innovative approach to training that gives individuals a basic understanding of the warning signs and what to do if they encounter someone who may have mental illness or a substance abuse disorder, particularly someone who may be in crisis and need rapid assessment. We tailor our mental health first aid training sessions to the needs of specific audiences, e.g., first responders, nursing home staff and non-behavioral health treatment providers. By offering tailored mental health first aid training to our network PCPs, we can enhance their ability to understand, respond appropriately and effectively coordinate care during mental health emergencies. We are excited to offer this program to Louisiana providers and other stakeholders. Across the country, we have conducted numerous mental health first aid training sessions to help the public at large recognize and understand mental health emergencies. This evidence-based public education program helps communities recognize signs of distress, dispelling myths and the stigma associated with mental illness, and addresses ways to support individuals experiencing a behavioral health crisis. Since 2010, we have provided more than 75 Mental Health First Aid trainings, for example in New Mexico and Washington, training individuals on how to assist someone in a crisis.
- Training on the availability of *liveandworkwell.com*. *Liveandworkwell.com* is our award-winning online behavioral health resource and information site – all of which help members avert crisis. Links on this site can be used to access online WRAP planning. This site also empowers members with information about behavioral health and medical conditions and has self-help articles and resources. Bayou Health members gain access to *liveandworkwell.com* through *myuhc.com*, our secure member portal.

Our member website focuses on substance use topics and makes it simple for members to find articles on a variety of wellness topics, take self-assessments, locate community resources, identify network clinicians and facilities, and download apps, such as our Whole Health Tracker. BeWell topics address healthy living, healthy aging, recovery and resiliency, addictions, mental health conditions and chronic medical conditions. Support focuses on improving coping capabilities and helping members and families make the most of their lives. The site is available to members and care providers.

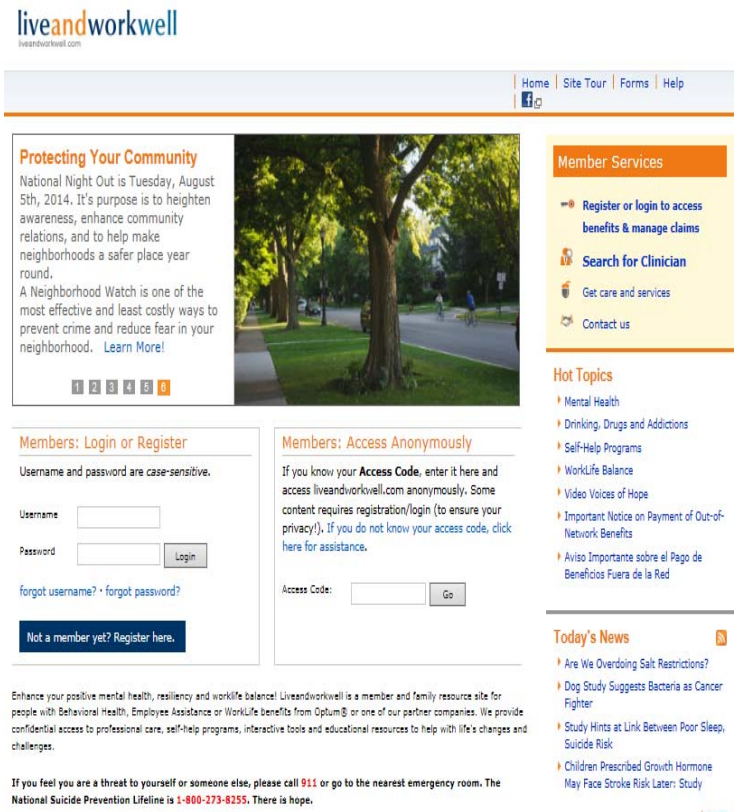


Figure 11. Through liveandworkwell.com, an on-line service site, members can do personalized research and request referrals for a variety of services.

Other resources, available via *liveandworkwell.com*, include health risk assessments (HRAs) to increase understanding, personal empowerment self-help programs and online journaling along with condition-specific centers on recovery, depression and addiction. A vignette series of 98 members share the journey to wellness to support members facing similar issues.

In 2013, 4 million users accessed 118 million page views and conducted 7.5 million transactions on *liveandworkwell.com*. *liveandworkwell.com* was awarded the Interactive Media Award's Outstanding Achievement Award (health care category) for design, content, feature functionality, usability, standards compliance and cross-browser compatibility and has also received the eHealthcare Leadership Award. In 2014, the site received URAC website accreditation and also holds NCQA and URAC Health Utilization Management accreditation. Our Spanish language site, *MenteSana-CuerpoSano.com*, was awarded the Health Care Best in Class Award at the 2008 Interactive Media Awards. This is the highest honor bestowed by the nonprofit organization, the Interactive Media Council.

PCP Behavioral Health Toolkit

We designed our *Behavioral Health Toolkit for the Healthcare Professional* (*Toolkit*) with the recognition that more than half of behavioral health issues are treated in primary care or other non-behavioral health settings. In some cases, the care delivered in these settings does not comply with evidence-based care or prescribing practices. The *Toolkit* is a convenient resource for health care professionals to guide them to our behavioral health clinical practice guidelines and evidence-based screening tools, such as the CAGE-AID substance abuse screener and the PHQ-9, a validated screening tool for depression. The *Toolkit* also explains how PCPs can

contact our behavioral health advocates and the SMO for assistance in accessing care for members who screen positive for a behavioral health condition. The *Toolkit* will be conveniently available to providers on BayouCloud, our secure provider portal.

To encourage screening in non-behavioral health settings, the *Toolkit* provides information on Screening, Brief Intervention, Referral and Treatment (SBIRT). SBIRT is an evidence-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and illicit drugs. The SBIRT model was cited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use. UnitedHealthcare reimburses providers who perform this screening as part of treatment or diagnosis; however, many providers do not understand the SBIRT billing process. Our *Toolkit* contains the Evaluation and Management CPT codes (99408 and 99409) and health care procedure codes (HCPC), H0049, H0050, G0396 and G0397, to help providers understand the reimbursement process.

Consultation Line

UnitedHealthcare will establish and maintain a PCP consultation line, which is a dedicated phone number for PCPs to access Dr. Freed, our behavioral health medical director, for consultation on behavioral health conditions, psychotropic medications, treatment interventions and to answer any other questions the PCP might have.

Coordination of Co-existing Physical and Behavioral Health Conditions

Our experience shows that behavioral health problems are more common in members with chronic illnesses, e.g., diabetes, arthritis, chronic pain, headache, back and neck problems, and heart disease. Left untreated, behavioral health conditions, especially those associated with co-existing physical health conditions, can result in poor health outcomes, e.g., functional impairment, poor adherence to treatment plans, adverse health behaviors that complicate physical health problems, and increased costs.

We will continue to work with the SMO to further opportunities for integrating behavioral health services in the primary care setting, including co-location of mental health and PCPs. One of the State's medical and behavioral health integration efforts is to encourage FQHCs and medical PCP practices to provide access to a co-located mental health provider or one that will work closely with a medical PCP office. We have been active participants in DHH's Medical-Behavioral Integration Summits as they work throughout the state of Louisiana to encourage this initiative. DHH is working in conjunction with Substance Abuse Mental Health Services Administration (SAMHSA) as a consultant to bring this effort to bear in Louisiana.

Prescription Management for Basic Behavioral Health Conditions

We require network PCPs to perform medication reconciliation for our members with prescriptions related to their behavioral health conditions. Keeping the member as the key focus, the PCP will leverage information about a member's preferences gathered by our staff during outreach when working with the member on a medication regimen. The member's assigned care coordinator or case manager, the behavioral health coordinator and/or community health worker collaborate to perform the following activities:

- Reach out to high-risk members to perform a behavioral health screen to identify over or under-utilization of services, including prescriptions.

- Engage members in understanding why they do not like medications or what their medication preferences are based upon previous experience, history, side effects, etc.
- Make sure members have a system in place to help them adhere to their medication regimens and support members by identifying barriers and working with the member to identify solutions, which may involve pharmacy auto-refills, using a reminder system or organizing medication by daily doses.
- Use motivational interviewing to establish trusted relationships to help a member adhere to a prescribed dosing schedule. Adhering to a proper medication dosing schedule may be difficult for an individual for many reasons, such as side effects, or simply because the individual lacks a stable place to live or cannot remember to refill a prescription.
- Make sure members have follow-up PCP appointments scheduled, as needed.
- Help members attend appointments, provide medication reminders and partner to provide recovery and resiliency-based services.
- Participate in interdisciplinary care planning.

Role of the Behavioral Health Medical Director

With an understanding of how a behavioral health issue can interfere with a member's ability to access routine care for co-occurring, comorbid medical conditions, we look forward to optimizing our behavioral health coordination by bringing a behavioral health medical director on staff. The medical director will have accountability for all coordination activities related to behavioral health services including but not limited to collaborative prescription management and education and engagement of providers around behavioral health services. Dr. Charles Freed, who is an experienced behavioral health medical director and has a Louisiana medical license, will serve in this role on an interim basis as we have actively begun recruitment efforts for a permanent, Louisiana based psychiatrist.

With regard to prescription drug management, our behavioral health medical director will:

- Oversee, monitor and assist with the management of psychopharmacology pharmacy activities, including the establishment of prior authorization clinical appropriateness of use and step therapy requirements for use of stimulants and antipsychotics for all enrolled members under age 18.
- Oversee medication adherence program, which addresses medication adherence and inappropriate prescribing, including oversight of prescribing practices related to specific groups of drugs, e.g., in appropriate or overutilization of opioids or ADHD-related prescriptions. The behavioral health medical director will promote safe prescribing practices to support clinicians and to ensure member safety.
- Work with care coordinators and case managers to alert providers to a member's non-adherence, which will in turn facilitate conversations with the member about why medications are not being taken as directed as well as discussions of alternate medication therapies that might be considered if side effects are a concern. Discussions may result in a referral to evaluation for substance use screening for members who may be abusing their prescription medications.

Engaging and Educating Providers

To enhance provider education, the behavioral health medical director will:

- Work with our medical management team to develop and deliver targeted education and training for Bayou Health PCPs and their staff. Educational materials will focus on behavioral health issues frequently treated by PCPs or those encountered in a primary care setting.
- Make sure training is designed in a way that encourages providers to embrace and address a member's behavioral health needs.
- Join chief medical officer Dr. Logarbo and medical management manager Linda Rintala, RN, to visit providers to provide education.
- Participate in integrated joint rounds with the SMO and other members of the ICT.
- Conduct pharmacology review of members with co-existing medical and behavioral health conditions and educate providers accordingly.
- Lead or participate on a behavioral health advisory board and a joint operating committee with SMO staff. We recommend medical/behavioral health integration as an ongoing discussion topic to facilitate feedback from PCPs and behavioral health specialists for continuous improvements.
- Work closely with provider advocates and clinical practice consultants who educate PCPs on their role in providing basic behavioral health services.
- Engage the SMO to identify additional opportunities where we can expand integration of our medical services into behavioral health practices.

To promote PCP coordination of co-existing medical and behavioral health conditions, our new behavioral health medical director will:

- Provide clinical case management consultations and clinical guidance for network PCPs treating behavioral health-related concerns, e.g., ADHD and depression, that typically do not require referral to behavioral health specialists
- Work with other MCO behavioral health medical directors to develop comprehensive care programs for the management of youth and adult behavioral health concerns typically treated by PCPs in a primary care setting

J.2 Describe how you will coordinate with the Medicaid Dental Benefits Manager for the management of shared members, including processes for reciprocal referral for needed services. (3 points)

Dental Health Services and Coordinating with the Dental Benefits Manager

We have established formal policies and procedures to coordinate the delivery of core benefits and services, including dental health services, which are reimbursed on a FFS basis by DHH's dental benefit program manager for children under 21 years old.

Identification of Members Needing Dental Services

We will work with the State's dental program manager and the member's PCP to coordinate the delivery of carved-out dental services to members in a timely manner, particularly for medically necessary dental services identified during routine EPSDT dental screenings. As appropriate, we include dental professionals on our members' interdisciplinary care teams. For members participating in an Accountable Care Community (ACC), dental professionals may, as part of the care team, be granted access to our BayouCare platform, which gives them electronic access to the member's plan of care and other member-specific clinical information. We identify members needing dental services through the following methods:

- The assessment process (HRAs conducted by member services staff) and comprehensive health status assessments and supplemental assessments (conducted by case management nurses)
- Member, family and PCP referrals (includes pediatrician for EPSDT dental screenings)
- Claims data (claims data related to using the ER for dental emergencies) and internal referrals based upon identification of member needs
- Admission, discharge and transfer (ADT)/hospital ER data via the Louisiana Health Information Exchange (LaHIE) and independent hospital feeds, indicating a member using the ER for dental emergencies
- Universal Tracking Database (UTD) reports (case manager reviews HEDIS gaps in care and takes the steps necessary to close gaps related to dental care)

For members participating in the case management program, the member's case manager and/or a community health worker serving as part of the member's interdisciplinary care team provide referrals and other assistance to connect members to the State's dental benefit program and dental resources available in the community. Information and assistance for all members is available from member services staff, in the *Member Handbook*, on the member portal (*myuhc.com)* and in our *HealthTalk* quarterly newsletters.

Coordinating with the State's Medicaid Dental Benefits Manager

We have experience coordinating carved-out dental services in Delaware, Massachusetts, Maryland, Nebraska and Tennessee. Integration and coordination of physical and oral health services is a priority due to the connection between medical and dental health. Our experience shows access to dental services reduces the incidence and treatment costs of a variety of diseases and conditions. Better integration of physical and oral health services improves our member's health outcomes and reduces costs. We currently provide educational information for PCPs in our *Provider Administrative Guide*, reinforcing the importance of timely dental services for children, promoting integration of primary and dental services. PCPs may provide certain dental procedures (e.g., application of dental varnishes) in a primary care setting.

Major Findings and Themes from Oral Health in America: A Report of the Surgeon General

- Oral health is more than healthy teeth.
- Oral diseases and disorders in and of themselves affect health and well-being throughout life.
- The mouth reflects general health and well-being.
- Oral diseases and conditions are often associated with other health problems.
- Lifestyle behaviors that affect general health, e.g., tobacco use, excessive alcohol use and poor dietary choices, affect oral and craniofacial health as well.
- Safe and effective measures exist to prevent the most common dental diseases—dental caries and periodontal diseases.
- There are profound and consequential oral health disparities within the U.S. population.

Primary care physicians have a key role in care coordination processes for members needing dental care and services. PCPs work closely with members, community health workers and case managers to educate members/families about dental hygiene and accessing available preventive dental care services. The case manager or community health worker works with the member, PCP, as needed, and the State's Medicaid dental benefits manager staff to coordinate the member's needed dental services. To coordinate dental benefits with the State's Medicaid dental benefits manager, we:

- Establish and maintain formal processes to identify members needing referrals to dental services
- Link members to an appropriate dental benefit program manager-provided or available community-based services
- Collaborate with interdisciplinary care teams, inviting dental professionals to participate, as needed
- Assist PCPs, the dental benefit program manager and members with the dental coordination referral process
- Share relevant clinical information with the dental benefits manager (with member consent)
- Incorporate input from dental professionals on the plan of care, invite them to participate in joint case rounds and consult on medication management and request their input on strategies for promoting member engagement in care and positive behaviors, particularly for members with periodontal disease and are pregnant or have chronic conditions
- Monitor care and health outcomes, particularly for members with co-occurring dental issues and chronic conditions or pregnancy

We will communicate verbally or via monthly (HIPAA-compliant) data reports to DHH's dental program manager listing our shared members who visited the ER for a dental condition within the previous month. With this data, the dental vendor can conduct targeted outreach to connect these high-risk members with the appropriate dental services.

Value-added Benefit – Dental Services for Adults

Because we recognize the importance of oral health to a person's overall health, we will offer a value-added adult dental benefit/program for members 21 years old and older not otherwise covered under Medicaid, as follows:

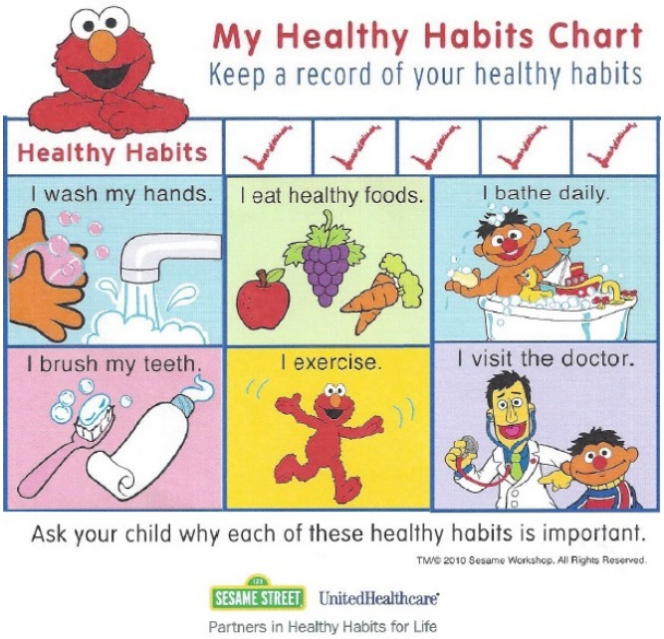
- Routine exams, x-rays, cleanings, fillings and extractions, including:
  - One comprehensive exam per year
  - X-rays once per year
  - Fillings and extractions
- Members must use in-network providers and have an annual benefit maximum of $500

Reciprocal Referrals Enhance Health Outcomes

Our processes for reciprocal referral for needed services include:

- Training for PCPs on dental-related HEDIS measures, the availability of covered dental services for the EPSDT-eligible members and how to refer members to the State's Medicaid dental benefits manager for identified dental needs.
- Training for PCPs on the importance of referring members who need preventive and restorative dental care services, the benefits available under the UnitedHealthcare value-added adult dental benefit and how to work with community health workers who can remove a member's barriers to accessing dental care.

- Criteria and processes for reciprocal referrals between UnitedHealthcare and the State's Medicaid dental benefits manager, including cross-training of respective staffs on referral processes.
- Education, outreach and information to members and providers targeting specific chronic conditions and the importance of preventive oral health (e.g., PCP refers member to dental professional for preventive services or treatment) as well as the warning signs of oral health problems exacerbating chronic conditions (e.g., dentist refers member to PCP for treatment of chronic disease). For example:
  - We encourage PCPs to refer pregnant members and members with diabetes or other chronic conditions to dental services. Community health workers can link members to community-based services.
  - Because of the link between periodontal disease and early newborn deliveries for pregnant women, our Healthy First Steps case managers encourage pregnant women to seek dental care and refer them to community-based dental services, as appropriate.
  - We encourage PCPs, including pediatricians to follow the American Academy of Pediatrics (AAP) Periodicity Schedule and refer the child's parent to a dentist to begin dental preventive check-ups and preventive treatments at 1 year of age. This practice reinforces the connection between oral and overall health and wellness. We encourage all members under 21 years old to complete age-appropriate dental screenings and assist with referrals to the State's dental program manager. We provide handouts to providers to encourage healthy habits.
  - We encourage dentists to refer shared members to UnitedHealthcare when medical issues are identified.



J.3 Describe your approach for coordinating other carved out services including but not limited to Person Care Services, Targeted Case Management and other waiver specific services. Please include a description of how you will identify that your members may be in need of these services and any processes you will have in place for referral to and follow up with the member and provider or payer as appropriate. (2 points)

Approach to Coordinating Other Carved-Out Services

As Medicaid programs carve in or carve out various services and programs, we have gained experience coordinating a full range of other carved-out services, such as personal care services, targeted case management and waiver services. We have experience working with these carve-out providers and have a clear understanding of when these services should be called upon to

support a member. Our approach to coordinating other carved-out services is similar to our approach to coordinating behavioral health and dental services, we:

- Establish and maintain formal processes to identify members needing other carved-out services
- Assist PCPs, members and carve-out service providers with the referral process
- Link members to appropriate services
- Collaborate with interdisciplinary care team members, including PCPs and representation from other carve-out service providers
- Educate providers and members about other carved-out service coverage, provision of and availability of other services and programs
- Monitor member care and health outcomes

In addition, Bayou Health members receiving other carved-out services may work with an independent case manager who advocates for the services these members need. We establish a link with the independent case manager so that we can coordinate the person-centered care and services these members need.

Personal Care Services

Personal care services (PCS) are critical for members needing assistance with activities of daily living (ADLs), which include eating, bathing, dressing and personal hygiene, as a result of a member's physical limitations (for example, due to a developmental or physical disability, a catastrophic medical condition, multiple comorbid conditions or injury). Personal care services are often necessary to support a member and to maintain the member in the least restrictive setting, e.g., member's own home. On the new contract, PCS are carved in for members 0 to 20 years old and carved out for members 21 years and older.

We have relevant experience assessing members for PCS services and coordinating PCS services with a carve-out vendor for Medicaid programs in New Jersey, Wisconsin and New York. We also have experience in these states with following up with members, providers and payers regarding services carved out. We will provide continuity of care and coordination of services for members who require PCS, providing timely referrals, documenting PCS services in the plan of care and coordinating care with the member's providers, with member/family consent.

Through our care planning process, we include the identification of appropriate home and community-based services (HCBS) a member may need. If needs are identified, we address and coordinate member needs with HCBS providers or carve-out vendors (depending on the member's covered services) across the full HCBS spectrum including PCS, transportation for medical appointments, home health care, adult day care, nursing home care, meal providers, personal emergency response systems (PERS), durable medical equipment (DME), assistive device technology and other supply vendors.

Identification of Members Needing Personal Care Services

At the start of a new contract, it is important that we provide continuity of care as previously outlined. Therefore, all members currently receiving PCS will be placed in case management to ensure continuity of their care and services. In addition, members identified in the DHH claims data as having a history of receiving PCS services will be placed in case management so that we can assess the need for these services and ensure members' needs are updated as part of entrance

into our plan. If the member is already receiving PCS, our case manager will request the member's consent to obtain information about the member's health status from the PCS case manager because the PCS provider is an excellent resource of information on the daily condition of the member.

Our case manager conducts a comprehensive health status assessment (CHSA) to determine or confirm the member's current needs, including PCS. Our comprehensive assessment incorporates a screening to determine if the member is currently receiving or is eligible for PCS. A list from DHH of members 21 years and older who are eligible for or enrolled in PCS would be a valuable tool to flag our members who may require more hands-on assistance with accessing services.

Referral Processes

As part of our care planning process, case managers determine whether the member requires any additional services. If an evaluation for PCS is necessary, the case manager makes an appropriate referral for an evaluation. If a member 21 years or older appears to need but is not currently receiving PCS, the case manager refers the member to the Office of Aging and Adult Services, assists as needed with making contact, and provides the assessment and other relevant information, with appropriate member consent, to assist the PCS provider with assessment and plan of care development.

Processes for Following Up with Members, Providers and Payers

The member's care coordinator or case manager documents contact information for the member's PCS provider in CareOne, our clinical management system. The care coordinator or case manager and the member's interdisciplinary care team coordinate any needed physician orders, obtain regular monitoring updates from the PCS case manager and share pertinent information about the member's covered services with the PCS case manager.

On an ongoing basis, care coordinators or case managers monitor the receipt of PCS and health outcomes related to those services. We incorporate personal care agency staff into the case management planning process, linking members to the necessary services and verifying that coordination takes place when appropriate. Case managers follow up regularly with members, providers, PCS providers and PCS case managers to get feedback on needed services and to update the member's plan of care.

Targeted Case Management

Individuals receiving targeted case management may voluntarily opt-in to managed care. Targeted case management includes nurse home visitation services that are provided for a targeted population of persons with special needs, including pregnant women and infants as well as members with a physical or developmental disability, as described in the Louisiana Medicaid State Plan. Targeted case management services help Medicaid-eligible individuals access a wide variety of health and human services that they might not otherwise be able to access. Members may self-identify themselves as having special needs. We have relevant experience providing similar targeted case management services in the state of Kansas.

For our members enrolled in carved-out targeted case management services, with member/family permission, our case managers coordinate closely with the assigned targeted case management nurse, especially in terms of an individualized plan of care, to help our members achieve better health outcomes. The case manager makes regular contact with the targeted case management

nurse to update each other on the member's health status, determine the need for routine assessment of health status and routine care as well as help the member access community resources and support. Our case managers and community health workers serve as trusted resources to targeted case management nurses and other staff.

Identification of Members Needing Targeted Case Management Services and Referral

We identify a member receiving targeted case management services during our new member welcome call, or we view DHH claims history indicating receipt of ongoing targeted case management services. For members receiving targeted case management services, a case manager contacts the member according to risk stratification level to conduct a comprehensive health status assessment, because receipt of targeted case management services may indicate the need for ongoing coordination of services and placement in our case management program. Case managers also identify members who may be eligible for but are currently not receiving targeted case management services, and therefore, will provide referrals and assist members in navigating the targeted case management eligibility process and accessing the services. We work closely with representatives of organizations that serve targeted case management-eligible members to identify additional mechanisms for coordinating services for members shared by UnitedHealthcare and the targeted case management service provider.

Processes for Following Up with Members, Providers and Payers

During the comprehensive assessment, the case manager obtains the name and contact information for the targeted case management provider. The member's case manager documents this information in CareOne and, with the member's permission, contacts the targeted case management provider to coordinate the plan of care. For example, if a member was hospitalized, the case manager notifies the targeted case management provider and involves the provider in transition care planning and discharge planning, as applicable.

Other Waiver-Specific Services

We have relevant experience and expertise coordinating other waiver-specific carved-out services in Kansas, Arizona and New Jersey where we provide acute services but waiver services are carved out similar to Louisiana. We are also one of the largest managed care organizations contracted to manage LTSS waiver benefits nationally, giving us extensive experience identifying waiver service needs. We serve more than 155,000 LTSS members and complex populations in 11 states, including Tennessee, Arizona, Delaware, Florida, Hawaii, Kansas, Massachusetts, New Jersey, New Mexico, New York and Texas.

Identification of Members Needing Waiver Services

We initially identify members receiving waiver services from claims history provided by DHH. Additionally, we identify members receiving waiver services using our HRA and subsequent comprehensive assessments. Through direct contact with members by case managers, member advocates and community health workers we may also identify members receiving other waiver services. **All members receiving waiver services who opt-in to the Bayou Health program will be assigned a case manager**.

Referral Processes

Our person-centered model of care allows us to view the member holistically and enables us to identify members who are in need of other waiver services but not currently receiving them. Once identified, case managers have processes in place to refer members for waiver services

through the DHH programs. Additionally we may identify members in need of waiver services through referrals from members, families and PCP and confirmed through comprehensive assessments.

Processes for Following Up with Members, Providers and Payers

Through our case managers we regularly assess members to ensure they are receiving all needed care and will follow up with PCPs and providers of waiver services to confirm the member is receiving the right care at the right time in the right amount. Case managers may include the member's waiver service provider in the members interdisciplinary care team if needed and will work to ensure that the member has achieved their personal goals and make recommendations regarding additional waiver services.

Section K: Case Management

K.1 Describe your approach to MCO case management. In particular, describe the following:

- Characteristics of members that you will target for case management services;
- How you assess member needs;
- How you identify these members;
- How you encourage member participation;
- What tools you will be using for patient engagement including technology or mobile aps;
- How you develop and implement individualized plans of care, including coordination with providers and support services;
- How you will get data feeds from hospitals when your member is admitted, discharged or transferred;
- How you coordinate your disease management and case management programs;
- How you will coordinate your case management services with the PCP; and
- How you will incorporate provider input into strategies to influence behavior of members. (5 points)

Characteristics of Members Targeted for Case Management

We use a population health approach to target service delivery to specific subpopulations of members based upon need. This approach is foundational to our overall model of care and therefore infiltrates every aspect of our delivery system, inclusive of UnitedHealthcare and state-managed programs, patient-centered medical homes (PCMHs) and Accountable Care Communities (ACCs). Population health is essential to our efforts to achieve the Triple Aim of better health outcomes, improving the care experience and lower costs of care.

The following illustration shows our population health risk stratification groups—general or most vulnerable—and the corresponding subgroups:

[redacted]

Our person-centered model of care is based upon population health, which considers the health of groups of individuals with the goal of improving health across the populations rather than

focusing on individual disease states. As seen in the illustration, we use our population health model to target the health needs of two primary groups of individuals along with subgroupings to improve health outcomes across the spectrum focusing on whole person care (behavioral, medical and social). The goal then is to use a population perspective to improve health at the individual member level, the subgroup level and the entire population. This approach allows us to engage the necessary services to address specific diagnoses, subgroups of chronic illness and population wellness and prevention in a tiered delivery system.

Within our *General* category, we include programs, such as wellness, low risk maternity, health risk management and care coordination. Members within the wellness program are identified by predictive modeling as meeting the following criteria: no identified health risks through telephonic health risk assessment (HRA) or claims history, no identified chronic conditions and no indication of pregnancy. Members in our low-risk maternity, health risk management and care coordination programs are identified as not meeting the wellness or most vulnerable categories and identified using predictive modeling as meeting the following criteria:

- (If not pregnant) may be eligible for the health risk management program. We enroll individuals with chronic disease prevalent in our member population or who are using significant health resources in their regional population. We use clearly defined criteria to sub-stratify these members into high, medium and low categories, report this information in our annual program description and provide the minimum-required interventions specified in the RFP.
- (If pregnant and not high risk) member is eligible for the low-risk maternity program.

Our *Most Vulnerable* members are medically fragile and are offered programs, such as: chronic care, high-risk pregnancy or complex case management. Using predictive modeling, referrals and HRAs to identify our most vulnerable members, these members are identified as being part of the top five percent of members, excluding high-risk maternity members, and are most at risk for adverse outcomes.

- Members identified as eligible for the chronic care program are not pregnant and have complex chronic conditions with multiple identified health risks or needs. They may have co-occurring mental illness and substance abuse or co-morbid physical and behavioral health conditions.
- Our most vulnerable members who are pregnant may be eligible for the high-risk pregnancy program.
- Members identified as eligible for the complex case management program are not pregnant and have high-risk, unique or complex needs. These members may have co-occurring mental illness and substance abuse or co-morbid physical and behavioral health conditions. We identify these members using utilization reports, such as a high pharmacy user or those who exceed the ER threshold defined by the State.

Case management services based on this model allow for rapid identification of members who can benefit the most from targeted programs. The focus of our case management program includes members who are stratified by the model as the most at risk and who fall into our conceptualization of most vulnerable members, which also includes members with high utilization (individuals in the top five percent of use of services). Often these members have acute and chronic health conditions with multiple co-morbidities, such as combinations of:

- Asthma
- Congestive heart failure (CHF)
- Diabetes
- HIV/AIDS
- Hepatitis C
- Obesity
- Sickle cell anemia (diagnosed members who are high utilizers of the ER and inpatient services)
- Hypertension as a precursor to coronary artery disease (CAD) and stroke
- Chronic obstructive pulmonary disease (COPD)
- Low back pain

We target case management services to members with comorbid chronic conditions using a variety of approaches outlined below to reduce future deterioration or exacerbation of their condition. Members are identified primarily through scores on our HRAs as well as the risk score on the Impact Pro, which is determined by claims data.

We have standardized, comprehensive clinical programs, and we will further customize our approach based upon the particular characteristics of members in the Bayou Health program as well as State requirements. The characteristics of the members we target for case management include those with the most significant illness burden, reflected in their predictive modeling scores, and whose conditions are most responsive to case management interventions. We target members with a wide variety of conditions and needs, including high-risk pregnancy, severe mental illness, diabetes, asthma, congestive heart failure, cancer, transplants, sickle cell, HIV/AIDS, chronic pain management, Hepatitis C, spinal cord injury, para/quadriplegia, amputations, multiple sclerosis, severe trauma with multiple system involvement, traumatic brain injury, ADHD, bipolar disorder, seizure disorder, cerebral palsy and co-morbid/co-occurring conditions.

We place a high priority on members' whose risk scores indicate they are at the greatest risk of hospitalization within the upcoming 60 days. Members with high utilization of services (within the top five percent of utilization of services) who may have frequent or inappropriate ER utilization and inpatient stays are a subgroup that is always targeted with case management services.

The criteria we have established for case management includes but is not limited to members or populations identified with:

- High risk (most vulnerable) or who have unique, chronic or complex needs or conditions (cardiovascular or pulmonary disease, diabetes, asthma, HIV/AIDS, sickle cell, etc.)
- Special health care needs, including individuals of any age with mental disability, physical disability or other circumstances that place their health and ability to function in society at risk, requiring individualized health care approaches
- Medical or behavioral health comorbid conditions (medical or behavioral), e.g., two or more active chronic diagnoses that are not stable

- Members who are at risk for developing a high-risk condition or who are at risk of hospitalization within the next 60 days according to predictive modeling Impact Pro score
- Two or more hospitalizations in the past six months with the same or related diagnosis or multiple ER visits in the past six months
- Medication management-related issues, e.g., non-adherence to prescribed medications
- High-risk pregnancy case management
- Significant impairment in one or more of the instrumental activities of daily living (IADLs), e.g., preparing meals, shopping, basic housekeeping, etc. particularly when there is a limited support system, including those already receiving personal care services
- Postpartum, such as women identified as high risk during the pregnancy, preterm birth less than 37 weeks, and those needing a referral to safety net services for inter-pregnancy care, and breast-feeding support, per RFP section 6.13.2
- Significant issues with social or economic constraints, e.g., lack of housing, lack of financial support, lack of social, family or significant other support, illiteracy or significant communication or cognitive barriers, access to care issues, transportation, or abuse or suspected abuse
- Most vulnerable members who are high-utilizers (top five percent) with frequent or inappropriate ER utilization and inpatient stays
- Member self-referral or other referrals, e.g., the statewide management organization (SMO) for behavioral health, for case management

We educate pregnant members about the benefits of participating in our Healthy First Steps program, which promotes healthy birth outcomes for pregnant members, especially those with high-risk pregnancies. Our high-risk pregnant members receive a Healthy First Steps OB clinical assessment, which includes a comprehensive review of obstetrical and medical history and a psychosocial assessment and drives the development of an individualized plan of care with interventions targeted to improve maternal and infant outcomes.

Pregnancy plan of care interventions focus on member education, e.g., signs and symptoms of complications, breast-feeding, nutrition and smoking cessation, as well as ongoing reminders and support on the importance of regular obstetrician visits. We also help pregnant members to access community resources, e.g., Women, Infants and Children (WIC).

For members identified with substance abuse and mental health issues, behavioral health coordinators make sure they access needed services. We educate members on the importance of scheduling postpartum and well-baby visits. Text4Baby, a free text-messaging program, offers information throughout pregnancy and, after delivery, information related to the postpartum period and infant care until the first birthday, and Baby Blocks is a reminder system that engages and rewards pregnant women during their pregnancy and in the first 15 months after delivery.

Healthplan Manager provides our health plan leadership with a targeted, data-driven strategic roadmap to optimize our performance as we evolve our programs, identifying the prevalence of specific conditions within the Louisiana Medicaid population. Healthplan Manager works with our Strategic Management Analytic Reporting Tool (SMART) data warehouse and adds to our analytical resources and reporting capabilities. Using a user-friendly graphical interface, it allows us to segment data using dozens of attributes to analyze financial, clinical and individual

decision-making patterns. Healthplan Manager includes integrated clinical, financial and pharmacy data on a geographic community level, making it possible to understand all of our members' population health needs; provides analysis that provide key insights that really matter to Bayou Health members; and accesses our robust data and experience across our health plan to provide benchmarks that can enhance case management services and programs. We can customize results to limit or compare our Louisiana experience to medical product offerings and virtually any other subset of Medicaid populations.

Assessing Member Needs

Our case managers assess member needs through various sources including: face-to-face interactions, telephonic discussion with the member about their health, review of available data regarding the member's health status, a member's stratified risk score and results from a variety of available telephonic screening tools. Screening tools provide specific information about the member's symptoms, health status and how health is affecting the member's overall quality of life. Combining these sources of information allows for a complete understanding of the member's current health status, how case management can assist the member, and the specific steps a member can take to improve or manage his or her own health over time.

[redacted]

Assessments

Assessments systematically drive identification of person-centered needs, goals and interventions to achieve best practices in chronic disease management.

Health Risk Assessment

Health Risk Assessment
We conduct a telephonic HRA for new members. The HRA includes:

- Complete demographic information
- Emergency room utilization in the last year
- History of hospitalizations in the last year
- Presence of co-morbid chronic medical and behavioral health conditions
- Ability to perform activities of daily living
- Perceived risks
- Self-reported health status
- Strengths-based needs and preferences

Risk identification begins with an HRA. We make it a priority to conduct a health risk assessment (HRA) for each member to align them with appropriate interventions, thus maximizing the impact of our Chronic Care Management Program (CCMP) efforts. Our integrated HRA is an integral part of our member outreach efforts, inbound member and outbound calls, workflows and provider partnerships. The HRA tool is algorithmically designed to assign population health stratification levels and used to prompt further discussion regarding a member's current and historical clinical, behavioral and

socioeconomic needs. This means we can align members with appropriate intervention strategies and maximize the impact of services provided.

The HRA reviews existing knowledge gaps and culturally sensitive insights that may influence health outcomes. We work with our provider network to identify members with special health care needs and use this information in the stratification, assessment and care planning. In the event a member calls into member services and has not completed an HRA, the system will route the member, based upon stratification, to a qualified staff member to complete the HRA and address the member's reason for calling. The HRA is an initial assessment tool used for new and existing members to identify a member's health risks. Based upon the member's response to a series of questions, the tool assigns a score that corresponds to a level.

[redacted]

- [redacted]
- [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Comprehensive Reassessments
The following needs or conditions may warrant a reassessment of a member:

- Hospitalization
- Significant change in medication
- Change in, or loss of, a caregiver
- Medical, social, environmental or BH crisis
- Excessive ER use
- Major changes in the member's medical, psychosocial or behavioral health

Comprehensive Reassessments

We complete reassessments when the member's condition or an event warrants a member reassessment. We will incorporate the results of reassessments into the member's plan of care and distribute the plan of care to appropriate interdisciplinary care team members, including members and their families (with the member's consent).

In-Person Screenings

Depending on a member's needs, case managers may conduct face-to-face (in-person) screenings. Case managers have access to our systems via UnitedHealth Group's secure virtual private network. CareOne (our medical management system) has an offline mode, which enables case managers to work with members at the point of care and synchronize data once connected to our network. Because CareOne is integrated with our claims platform, CSP Facets, case managers can access information from member claims or reporting systems to coordinate care. CSP Facets provides eligibility, enrollment, claims processing, benefits configuration, capitation and reporting capabilities and provides the source data for other system applications used for case management-related activities.

Identifying Members for Case Management

Risk profiling and risk stratification are critical factors for achieving optimal clinical outcomes and are the foundation of successful clinical programming, encompassing case management and chronic care management. Early identification and intervention is especially important for high-risk members and those at risk for developing increasing disability. Our protocols focus on identifying members who can benefit most from an integrated plan of care and a case management program based on a tiered approach to population health.

The HRA and our predictive modeling and stratification system are our primary tools for identifying members for case management. To identify members with multiple chronic diseases and gaps in care, we analyze condition-specific reporting from the SMART data warehouse and various data analytical reports: inpatient admission/readmission reporting; Impact Pro monthly data analysis, including lists of members with comorbid conditions; and identification of members with high utilization of services.

Considering diabetes, for example, we review pharmacy data and claims for hospitalizations or ER visits occurring during the last six months to evaluate preventable diabetes complications. For asthma, we analyze prior and real-time utilization (e.g., ER, pharmacy, inpatient) to proactively identify member's asthma.

Risk Stratification and Data Analytics

Our multi-dimensional, episode-based predictive modeling tool, Impact Pro, compiles information from multiple sources, including claims, laboratory and pharmacy data and uses it to predict future risk for intensive care services. Impact Pro uses a variety of evidence-based algorithms and models to predict which members are at greatest risk for severe health care problems in the future.

Impact Pro's automated algorithms forecast future health risk and stratify high-risk members and provide information to help build the intensity of care management interventions—crucial data analytic capabilities that assist in the production of targeted reports and, in turn, effective member interventions. Algorithms identify members who have a history of ER use, repeat hospital admissions, high utilization of medical outpatient services, potential quality of care issues or an indication of multiple providers of services that appear to lack coordination.

Risk scoring and the stratification system within Impact Pro allows us to identify cohorts of members with multiple chronic diseases and behavioral health issues and to support enhanced case management by targeting the highest risk members and gaps in care. Case management staff evaluates this information and identifies members with the highest level of risk for further

assessment. An "Overall Future Risk Score" is assigned to each member and represents the degree to which the disease management program has the opportunity to have an impact on members' health status and clinical outcomes. This assists our care managers in identifying members who are most likely to benefit from interventions.

Ongoing risk can be evaluated through service utilization triggers, practitioner referrals and sophisticated claims analysis. Through careful risk profiling, we have an early warning system to identify members who are at risk for requiring higher levels of care at a later date. By reaching out to these members, we can provide the services needed to support optimal health in the setting of the member's choice.

We will begin our data collection process with claims and other data we receive from the State (and other health plans) for new members coming into the plan. We will augment that from real-time admission, discharge and transfer (ADT) data from hospitals on ER and inpatient visits. Risk assessment and stratification begin with the assessment process. As claim, service authorizations and predictive modeling data become available; we use these analytic tools to further predict risk:

- ***Significant Episode Cluster Activity (SECA)*** reports identify members with four or more ER or two or more admissions within a 6-month period.
- ***Blended Census Report Tool (BCRT)*** identifies and tracks members in facilities, including readmissions for the same reason within 10 days.

Using Impact Pro, we can identify members who may not yet have a diagnosis or identified condition that would trigger assessment for case management or those who may be at risk for future utilization. In addition, we have community nurses located at our Accountable Care Community provider sites to help providers identify members who may benefit from case management.

With appropriate case management and monitoring, we can prevent, delay or reduce the chronic disease process and the need for high utilization of services by connecting these members to appropriate preventive and primary care as well as community resources. We evaluate risk scores and assign a range to each stratification level. Regardless of the risk score calculated by Impact Pro, members with specific conditions automatically trigger case management assessments, including:

Proactive Identification of High-Risk Pregnancies. In compliance with RFP section 6.37.3.2, our case management identification criteria, process and triggers for referral and admission into a perinatal high-risk case management program include:

- Reproductive aged women with a history of prior poor birth outcomes
- High-risk pregnant women

We proactively identify current members as pregnant through lab and physician claims as well as pharmacy claims for prenatal vitamin prescriptions. We leverage a pregnancy fast-track process for all new members identified as pregnant on their 834 enrollment file, through new member welcome calls or through obstetrician risk assessments completed at a first pregnancy visit.

Other Identification Strategies

We have a comprehensive outreach program that supports identification and referral for case management services. Our case management staff collaborates with other community partners, such as program care managers, clinic staff, other health care team community partners and fiduciary entities, to identify members. In addition to claims and pharmacy data, we integrate authorization and pre-certification information into our case management identification stratification methodologies.

For members transitioning into UnitedHealthcare from another plan or program, we outreach to the relinquishing health plan and their care manager for the member's claims records, plan of care and service authorizations so that we can identify members for participation in case management and continue medically necessary services. Additional identification strategies beyond risk profiling include:

- ***Enrollment Data:*** In addition to assessments, we use enrollment data (including the State's enrollment file), DHH eligibility data and DHH historical claims data. For members transferring to UnitedHealthcare, we review the information from another MCO to look for indications of chronic or complex needs and the need for case management and an immediate member assignment to a case manager and a CHSA completed.

  PCPs conduct in-office screening (diagnostic assessment) and may identify members as having special needs at any time the member presents with those needs, including pregnant women. We will assess those members identified as having special health needs within 30 days of identification. In addition, we use other information provided at enrollment (e.g., existing authorizations for specialty services, non-emergency transportation and certain supplies, including oxygen and enteral nutrition) to identify members who may need case management services.

- ***Making Direct Member Contact:*** We also identify members who need or desire case management services when:
  - Members express a desire when contacting member services
  - Our health services department receives an authorization request
  - When a member is admitted to the hospital or seeks care in the ER

  All UnitedHealthcare clinical staff that engages with members has access to the information in CareOne, which indicates whether the member has completed an HRA, comprehensive assessment or has claims, prior authorizations or other indicators that the member may have special needs requiring case management services.
- ***Service Utilization/Care Triggers:*** We review ER reports, inpatient census, hospital discharge summaries, service authorizations and transitional coordination of care requests for all care needs.
- ***UM Referrals:*** Referrals from concurrent review, service authorization or precertification.
- ***Provider Referrals:*** Providers are educated on case management and CCMP programs as well as the process to refer members who are high risk.
- ***Member Self-Referrals/Family Referrals:*** Members/families receive information on the availability of our care coordination/case management programs and CCMP and the process for members to self-refer. We monitor member-reported health needs during calls

to member services. We maximize self-identification and self-referrals by pregnant women by educating all members about the positive benefits of early prenatal care and the Healthy First Steps program. We may receive referrals by phone, fax, mail, email or through our member and provider portals. When a referral is received, the member is contacted by phone. For high-risk members, contact is made within expedited timeframes.

- ***State or Other Local Government Referrals:*** Referrals may also be received for members in special needs populations, e.g., pregnant, ventilator dependent, members having targeted chronic conditions defined by contractual requirements, by DHH or other local government entities.
- ***Other Referral Sources:*** Referrals may be received for case management from multiple other sources, including but not limited to: member services representatives and outreach coordinators, health wellness and education programs, ER staff, community programs, hospital discharge planners, NurseLine staff and SMO staff who may flag a member with special health needs in addition to his or her behavioral health needs.

Strategies to Encourage Member Participation in Case Management

Our approach to case management encourages member participation at each point in the care continuum. Case managers use motivational interviewing techniques, reminders and referrals to community resources to foster member engagement and help members recognize the benefits of participating in case management. Case managers receive education and training on the tools and techniques used to encourage and enhance member participation in assessment and care planning processes. We provide details of the strategies we use to encourage member participation in case management programs, including:

New Member Welcome Call and HRA: During these activities, we inform members of available programs. Based upon HRA results, we may encourage the member to participate in specific programs, e.g., case management or Healthy First Steps, relevant to the member's health status. We are working to make available an online version of the HRA via *myuhc.com* and mobile devices, e.g., smartphone or tablet. Providing an online HRA offers members an additional choice for how they engage with us.

Interdisciplinary Care Team: Members of the interdisciplinary care team, including the member's PCP, family members, caregivers, community agencies or organization, and community health workers, are in a position to influence members and encourage them to participate in case management programs that increase wellness and improve quality of life.

Motivational Techniques: Our case management program uses a proactive approach that promotes members' self-management skills. By using motivational interviewing techniques, such as teach back, we can engage members and cultivate internal motivation to take steps to achieve their goals for improved health and wellness by participating in case management programs. We use these techniques in conjunction with readiness assessment tools that measure a member's knowledge, skills, ability and willingness to make changes and manage health (e.g., participate in care planning process). We continually track a member's state of readiness, document it in the member's plan of care, and provide ongoing encouragement and support to reinforce positive changes.

Care Planning Process: Personal and cultural choices support informed decision-making by members and their families during development of plan of care goals. Case managers contact members, provide reminders about preventive care and monitor a member's progress toward meeting their goals. It is important for them to set personal goals in their plan of care to increase engagement. We ask for at least one member requested goal in the plan. We use the Patient Activation Measure (PAM) to assess the level of member engagement over time.

Members are at the center of our care planning process. During care planning, we work closely with the member to develop a person-centric plan of care. Personal health and wellness goal setting are part of engaging the member during the plan of care development process and encouraging them to participate in programs that will help them meet their goals to improve health outcomes and quality of life. Case managers recognize and respect goals.

Ongoing Outreach and Education: We provide ongoing outreach and education to encourage members who newly qualify for the case management program to participate. Community health workers using a peer support-oriented approach encourage members who are eligible for case management to participate by reinforcing the benefits. We also provide outreach and education to members specific to their condition(s), reinforcing the member/PCP relationship and the importance of attending follow-up PCP appointments. We leverage discharge planning activities to facilitate the member engagement processes, e.g., educational component of the Coleman Model.

Enroll Members in our Accountable Care Communities (Enhanced Patient-Centered Medical Home): We encourage members to enroll in an ACC. Our local community nurses work closely with ACC providers and case management staff to help them engage members through the use of prevention and early intervention strategies, improved access to community-based services and support from community health workers. ACCs are structured to:

- Ensure members with special needs receive appropriate care and timely case management
- Promote community inclusion of individuals with physical and/or behavioral health conditions
- Increase provider implementation of evidence-based practices that integrate behavioral and physical health services
- Support compliance with evidence-based practices of pharmacotherapy

Tools Used for Member Engagement

We encourage members to participate in the case management program and engage them in their care using successful strategies already used in Louisiana. Member participation in their own care contributes to a greater level of engagement, optimal health outcomes and quality of life. Support and education helps to sustain their ongoing involvement. To address these needs, we provide multiple levels of support and information to support our members' choice of participating in case management including:

Active Engagement in Plan of Care Development: The plan of care is developed with the member and incorporates his or her goals for health. Case managers help members prioritize goals and set attainable benchmarks for continued success. The person-centered plan of care maps the member's physical, behavioral and psychosocial needs, primary care and specialty provider roles and services, home environment, transportation needs, etc. It documents an

agreed-upon set of goals for the member. The plan of care is accessible and approved by all the members of the interdisciplinary care team, which serves as the framework to guide care management decisions.

Trigger Care Events: Trigger care events, such as an inpatient stay, excessive ER use, or a new diagnosis are opportunities for the case manager and the PCP to engage a member on a path to better health and wellness, and appropriate use of resources. These events can also engage members in developing a plan of care when they are most motivated for change.

Face-to-Face Interaction: We are implementing programs that provide "high touch" case management for targeted groups of our most vulnerable members and the top five percent of utilizers. For members who are identified or stratified at the highest risk for poor health outcomes, our case management program may include face-to-face interaction. These face-to-face meetings are used to conduct more in-depth health questionnaires, develop the individualized plan of care and make changes to the plan over time, as the member's needs change. These visits can be used to help the member identify valuable local community resources and supports to help the member reach health and wellness goals. Community health workers work closely with case managers, engage our most vulnerable members and help members remove barriers to accessing care.

Member Outreach and Education: We have many forms of member outreach and education, including:

- ***Newsletter:*** *HealthTalk* is our quarterly member newsletter with relevant health education topics, including articles on behavioral health (e.g., attention deficit hyperactivity disorder, suicide prevention) and physical health (e.g., asthma, diabetes, pregnancy, heart health, women's health).
- ***Chronic Disease-Specific Management Mailings:*** Chronic disease management mailings are sent to newly identified members diagnosed with chronic conditions, such as asthma, diabetes and CHF, with telephonic or in-person follow up by a registered nurse to perform an additional assessment and provide further chronic disease management and member support. These mailings contain educational information to assist the member with managing their condition.

Figure 13. *HealthTalk* is our quarterly member newsletter.

- ***Educational brochures:*** Educational brochures, designed to teach readers about preventive care and other topics, are disseminated at community events, schools and provider offices. Some examples include:
  - Check-ups are Important
  - Keep Your Health in Check: Healthy Checkups for Adults
  - Be Wise…Immunize
  - Managing your Weight

- Tips on Talking with your Doctor
- Emergency Room Diversion Flyer: Where to Go to Get Well

Culturally Competent Care: To provide culturally competent care, we maintain policies, procedures and services that:

- Recognize members' beliefs and customs
- Address cultural and linguistic differences through the use of innovative technologies and local community-based staff
- Foster staff and provider behaviors that effectively address interpersonal communication styles that respect members' cultural backgrounds and diverse abilities
- Bring cultural awareness into the delivery of care to members through the creation of a Cultural Competency Plan

Member Incentives: [redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

Provider-Based Assistance: We contact providers (including pharmacists) and inpatient facilities to get updated contact information so that we can contact and engage members who are eligible for case management.

Members Who Are Difficult to Engage: Medicaid is an important safety net for our most vulnerable members. The combination of poor contact information, unstable housing, overwhelming socioeconomic challenges, and, in some instances, lack of trust, can make finding and engaging members with chronic illnesses and mental health and substance abuse issues difficult. Therefore, we have made investments in creative and persistent approaches to locate and engage difficult-to-find members. In Louisiana, our person-centered care model will increase

use of community health workers to help us locate and engage members so that we can close gaps in care and to encourage members to contact us, to get preventive health care services and to participate in case management programs for which the member is eligible. Community health workers continue to work closely with members to remove barriers to accessing care and to close gaps in care. They:

- Educate parents and guardians about the importance of routine screenings, vaccinations and taking all medications as prescribed
- May inquire about other children who are living in the home
- Offer assistance with making provider appointments, attend provider appointments, provide medication reminders and partner with case managers to provide recovery and resiliency-based services, and connect members to community resources
- May participate in interdisciplinary care planning, as appropriate.
- Conduct on-site visits when members are admitted to the ER or hospital. This face-to-face interaction with the member helps to build trust, lets the member know we are there to provide help and encourages the member to stay in contact with the case manager and PCP, and to schedule a follow-up appointment.
- Use Healthify, a searchable repository of local community resources, and their local knowledge of available resources to connect members to available local resources

Beyond Telephonic Outreach: The case manager makes three attempts to contact the member by telephone to assure a PCP appointment has been scheduled. If unable to do so after three attempts, the case manager may:

- Send the member a letter requesting the member contact the case manager or the PCP's office to schedule an appointment as soon as possible
- Contact our member services center to obtain their assistance with outreach to schedule the member's PCP appointment
- Request help from a community health worker to locate and engage the member, and to assist with setting up the PCP appointment
- Attempt to make face-to-face contact by conducting a "drive by," i.e., going to see the member at home or location identified by a community health worker or member services representative

Integrated Member Information and Ongoing Monitoring: Case managers continually review member information, keep up with changes in status and monitor those changes and update the member's plan of care, typically every 30 days, or more frequently if necessary.

Assistance at the Point of Service: If the member needs assistance, the case manager or community health worker may attend the member's PCP appointment at the point of service. Prior to the appointment, we prepare the member on how to engage with the PCP, e.g., bring medication list to the appointment.

Technology and Mobile Apps Offered to Drive Increased Engagement

UnitedHealthcare offers a number of technological advancements designed to simplify and enhance a member's health care experience. **Baby Blocks** is a reminder system that engages pregnant women during their pregnancy and in the first 15 months after delivery. Under this

program women receive personalized reminders via cellphone along with incentives to encourage prenatal and well-child visits in alignment with professional standards.

Through video game playing, we can help members change behavior related to personal health. To achieve this, we have piloted a number of activity-oriented innovations, including video game and wireless activity device integration, to support health and wellness goals. Our **Health4Me mobile app** helps members evaluate options and make choices to meet individual needs and preferences.

Because many Medicaid members lack reliable telephone access, their ability to contact a case manager or provider with questions or to report a change in condition is hampered. It also interferes with the case manager's and the provider's ability to reach the member with education, reminders and other information critical to their care. We will offer cell phones in Louisiana as we have done in other states (e.g., Tennessee and Mississippi) where we will link our high-risk members who lack reliable phone access (e.g., homeless, no home phone), to restricted-use cell phones. The phones can be pre-programmed with important numbers, such as the PCP, other treating physicians, the case manager, NurseLine (our after-hours nurse advice line) and 911. By providing a member with reliable phone access, we provide them with the means to contact critical members of their health care team and empower them to accept more personal accountability for their health care needs.

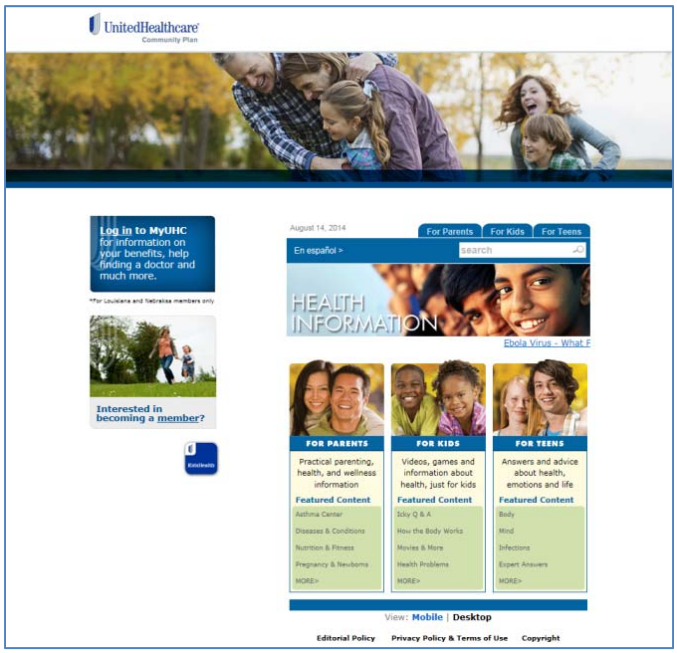


Figure 14. *LiveandWorkWell.com*. Through a link on *myuhc.com*, Bayou Health members have access to *liveandworkwell.com*.

Through a link on our secure member portal, *myuhc.com*, Bayou Health members, families, providers, community agencies and other stakeholders will have access to our website, which provides information on a variety of topics including wellbeing support, recovery and health management. In 2013, the *liveandworkwell.com* portal was used by 4 million visitors, who accessed 118 million page views and conducted 7.5 million transactions. *Liveandworkwell.com* was awarded the Interactive Media Award's (IMA) Outstanding Achievement Award (health care category) for design, content, feature functionality, usability, standards compliance and cross-browser compatibility. The site also received the eHealthcare Leadership Award. In 2014, we received URAC's website accreditation. The site has also achieved NCQA and URAC Health Utilization Management accreditation.

A companion website, *MenteSana-CuerpoSano.com* (Healthy Mind-Healthy Body), which can also be accessed via *myuhc.com*, is the award-winning affiliated site to *liveandworkwell.com* for Spanish-speaking members. *MenteSana-CuerpoSano.com* is not simply a Spanish translation of *liveandworkwell.com*, but rather, it is a site focused on providing culturally relevant material for Hispanic/Latino members. Users access a link through *liveandworkwell.com* for this extensive

Spanish language content, which uses a community and family-focused approach to help remove any cultural stigmas to members seeking information about behavioral health care.

Other important technology innovations available for Louisiana Medicaid include:

- [redacted]
- ***Public Website:*** We provide a public website, *uhccommunityplan.com*, which provides the public with plan information such as enrollment, benefits, eligibility, finding a provider, important links to health information, etc. This website provides members with the ability to choose English or change the language to Spanish or Vietnamese.
- ***Member Portal:*** We maintain a secure member portal available only to members through the website, *myuhc.com*, to provide information such as telephone contact information, the *Member Handbook*, a searchable list of providers, health care services history, benefits and coverage information, member rights and responsibilities, information on how to file grievances and appeals, etc.
- ***Text4Baby:*** We encourage expectant mothers and new moms to connect with the Text4Baby service. Through this service, educational text messages are sent to members with information about pregnancy and child care. Text4Baby sends messages to members appropriate to a member's stage of pregnancy. One of the first messages Text4Baby sends is a reminder to connect with a prenatal care provider.
- ***Social Media:*** In 2015, we plan to expand our social media footprint in additional channels (such as Facebook) to meet our members where they are and provide them with valuable plan or health and wellness content, as warranted. Social media users can now connect with us through Twitter to obtain educational tips and health care information. Our national Twitter handle @UHCPregnantCare targets our TANF audience who parallels Twitter demographics. @UHCPregnantCare's messaging delivers health and wellness information relating to pregnancy, child birth and general health information applicable to pregnant women. We launched the first enterprise Spanish handle in January 2014. @UHCEmbarazada (UHCPregnancy) has the same content as @UHCPregnantCare, but the Spanish handle gives our audience the option to choose their preferred language. All promotional materials are offered in Spanish as well.
- ***Smart Patient:*** We provide mobile users with the free Smart Patient application. This allows mobile device users to track important numbers such as blood pressure, record appointments, record doctors' orders, view educational videos, etc.

- ***OptumizeMe:*** The free OptumizeMe mobile application allows users to set health and fitness goals, challenge other users to set their own goals and post the results on Facebook.
- ***DocGPS:*** We provide mobile users with the free DocGPS mobile application. This enables mobile device users to search our provider network and obtain travel directions to a provider's location.
- ***KidsHealth®:*** Our online KidsHealth program includes resources that are provided to assist high-risk members with managing their conditions, such as diabetes, asthma and stress, and adopting a healthy lifestyle. Videos and written and spoken articles are provided to children, teens and their parents, who can engage with this program through a link on our public website, *uhccommunityplan.com*, and can be accessed through a computer, tablet or smartphone.

Developing and Implementing Individualized Plans of Care

We treat the whole person—not just the disease.
Our proactive case management program offers individualized support, education and case management customized to meet the member's unique needs.

Our care management program is based upon a (whole) person-centered, integrated approach and is customized to specific populations, including high-risk members with multiple chronic conditions, members with special health care needs, and members with basic or specialty behavioral health needs, physical health needs or functional and cognitive limitations. A person-centered approach means going beyond assessment data to gain in-depth understanding and insight into the member's unique needs and goals so that we can create an effective treatment solution for the member and his or her family. Working collaboratively with the member, family members and PCPs, the case manager uses a team-oriented approach and motivational interviewing techniques to define a member's goals, assigning resources and reaching agreement about the interdisciplinary plan of care.

Our experience indicates members benefit most when social supports and behavioral and physical health care are integrated and when the plan of care is created in concert with the member, family, providers, specialty providers and personal assistants who provide care. If a Bayou Health member has specialty behavioral health needs, the case manager communicates and coordinates directly with SMO case management staff. The plan of care is part of an overall approach to effectively identify, treat and coordinate care for those with co-occurring disorders as well as co-morbid medical conditions.

Our case managers follow written policies and procedures that guide the use of assessment information to develop the plan of care. The person-centered plan of care is an integrated plan and is strength-based, highlighting member attributes that can serve as a foundation for achieving positive outcomes and individualized to each member's unique situation and needs. We involve members in plan of care development, supporting them to reach their self-defined goals. A holistic and person-centered approach is critical to facilitating the member's commitment to the plan of care.

Members actively participate in the interdisciplinary care team and make decisions about their care and support, further promoting independence and autonomy and ensuring the plan of care reflects the member's wishes and goals. A person-centered plan of care lists any barriers to case management service delivery and strategies to address those barriers, as well as the measures

taken to reduce risks without restricting the member's autonomy to undertake risks and achieve goals.

We develop an appropriate person-centered plan of care for all members eligible for case management and those determined to be at high risk. Trigger care events, e.g., hospitalization, prompt a plan of care review and, if necessary, the plan of care is modified. Case management leadership monitor plans of care to make sure they have all required elements and at least one member-defined goal.

The plan of care is stored in CareOne, our clinical management system, and in our Web-based BayouCare Platform in an easy-to-read format. A printed copy of the plan of care is given to the member, PCP and other key providers involved in the member's care. The plan of care is written in a culturally and linguistically appropriate manner that enhances the member's health literacy, while considering their capacity for learning and self-management.

For members transferring to UnitedHealthcare, we obtain the member's current plan of care from the previous health plan. In this instance, we develop a new plan of care with an emphasis on avoiding duplication with existing resources, e.g., carved-out services or sources of care management outside of UnitedHealthcare. For all transferring members, we collaborate with the relinquishing health plan to facilitate a seamless transfer of clinical, utilization, prior authorization and other relevant information to our Bayou Health program.

Person-Centered Plan of Care with Goals and Timelines

The plan of care is the roadmap outlining the member's identified needs, goals and interventions, expected outcomes and measures, and specific timelines for achieving member goals, e.g., lose 5 pounds by the end of the month.

The plan of care reflects:

- Special health care needs, conditions or issues (medical, behavioral or social) and other critical member needs, such as legal or housing, expressed by the member
- Conditions or issues identified by the CHSA and/or the interdisciplinary care team
- Targeted (short-term and long-term) goals expressed by the member
- Chronic care issues
- Formal and informal supports as well as family members involved in the member's care
- An emergency backup plan for members receiving case management and other ongoing services
- A list of services covered by UnitedHealthcare as well as out-of plan services, including service type, amount, duration and frequency

Active referral management (including community-based resource referrals) results from a combination of processes related to the CHSA, plan of care development, interdisciplinary care team meetings and weekly joint rounds. The case manager, community health worker and the interdisciplinary care team actively identify available community-based resources, discuss them with the member, manage appropriate referrals, advocate for access to care and services, coach members to engage them in self-care and perform follow-up activities related to required services. Plans of care are most effective when they are living, dynamic documents that are shared with interdisciplinary care team members to get their input.

Ongoing monitoring and measures: Case managers review plans of care during initial contact and update it during each subsequent member contact, noting completed tasks, e.g., picked up prescriptions, and member goals accomplished. Updates to the plan of care are ongoing and made on an as needed based for members with changes in condition or circumstances.

Member rights: We assure the plan of care considers strategies for resolving conflict or disagreement within case management processes. UnitedHealthcare informs members, verbally and in writing (*Member Handbook*), about their rights and the process to appeal a denial, termination or reduction in service.

Determining Type of Service, Amount and Frequency

We offer members a flexible provision of services, which may include services that facilitate a member's ability to remain living safely and independently in his or her community. Our CareOne system is the foundation for the assessment and the care planning processes. We designed our CareOne application to coordinate the information flow among caregivers, case managers, members and providers. CareOne also includes behavioral health screening and assessment data. CareOne features include:

- Maintaining HRAs
- Creating and maintaining plans of care
- Managing prior authorizations
- Case management and care coordination
- Utilization management
- Standard and ad hoc reporting

CareOne houses a global profile of the member's health record and therefore facilitates better understanding of our members' physical, behavioral and social/environmental needs. CareOne serves as the framework for our virtual medical record, tracking clinical information longitudinally. CareOne supports management for integrated physical and behavioral care. Follow up is facilitated by CareOne's automated tasking and reminder system. If a case manager does not close open tasks that meet evidence-based guidelines, the tasks automatically escalate to the case management supervisor for intervention (e.g., coaching, load balancing, etc.).

CareOne produces reports that can be shared with providers to aid in treatment plan development and decision making. When our innovative technology is combined with our experienced case managers and proven care management programs, the result is the finest "high-tech/high-touch" care possible for our members.

Supplemental assessments help us determine the type of service, the amount of service and the frequency of the service needed to help members meet their care goals. Information about a member's knowledge, values, beliefs, circumstances, activities, medical, social or behavioral health needs and gaps in care is integrated into a person-centered, written plan of care, outlining the services used to support the member.

In addition to the member-specific aspects of the plan, we use established plan of care guidelines and document the medical, behavioral health and social services members receive. For facility-based services, we apply appropriate level of care criteria for specific services (e.g., inpatient

hospitalization). This specific criterion, national or as outlined by the State, provides guidelines for transition of care, applicable discharge criteria and delivery of waiver services.

Coordination with Providers and Support Services

Coordination of care and services between PCPs (including those affiliated with ACCs), other providers (including specialty providers) and our CCMP is consistent and seamless. Case managers work closely with members, their families/caregivers and PCPs to identify and coordinate services. Providers have access to the plan of care, facilitating their engagement and active participation in coordinating care and services for our members.

Provider Access to the Plan of Care

Goals and actions in the plan are adjusted over time to meet the member's changing needs. Case managers work closely with PCPs and continually assess each member's current status and needs. The case manager assesses whether current medical and pharmacological interventions are consistent with the member's medical condition. The case manager discusses any recommended changes with the PCP and assists the PCP and member to obtain any additional services needed to continue with treatment without any disruption in care.

In addition, the case manager works with our behavioral health coordinator for members with a psychiatric diagnosis or substance abuse issue to make sure appropriate behavioral health treatment and supports are included in the plan of care. The behavioral health coordinator works actively and closely with the case manager and the PCP to connect members with necessary services and supports in the community.

We fax or mail the plan of care to a provider and contact the provider via telephone for input into the member's plan of care. Providers are invited to send input verbally or via mail or fax. Our next generation of tools will provide online access to the member's plan of care via BayouCare Platform and the BayouCloud, as discussed later in this section.

Admit, Discharge or Transfer Data Feeds from Louisiana Hospitals

LOUISIANA HEALTH INFORMATION EXCHANGE

We are the only health plan with an active contract with the Louisiana Health Care Quality Forum (LHCQF), the entity that built and supports Louisiana's health information exchange, known as LaHIE. As of August 21, 2014, we had a live data feed and began receiving ADT data from 44 hospitals participating with LaHIE. Additionally, we have separate ADT feeds from 10 additional facilities, not included in LaHIE. We receive this information daily for our members who visited the ER over the preceding 24 hours. We leverage this data, which includes member-specific elements, such as diagnosis, to populate our Population Registry, providing us with an opportunity to improve care transitions for our members in Louisiana.

> Our ACC transformation consultants generate reports from data fed into the population registry for our providers, while our ACC nurses train the provider staff on its use and integration into their practices from the ADT information received via the Population Registry.

Sharing this information with providers through our Population Registry significantly improves hospital transitions, assists providers with coordination and continuity of care, and improves health outcomes for our members who transition between care settings. Notifications and alerts improve the timely flow of information so that providers and case managers can quickly and

effectively address the health care needs of these members and follow up within seven days of discharge. Case managers, discharge managers and community health workers collaborate to determine the need for face-to-face contact with our high-risk members who are admitted for an inpatient stay and to coordinate care upon discharge.

The Institute of Medicine Report, Crossing the Quality Chasm: A New Health System for the 21st Century, identified health information technology (HIT) as a means of supporting care management and quality of care. Electronic health records and HIT have great potential to assist with continuity of care. As stated on LHCQF's website, information technology's "next step involves the ability to securely exchange health information within and across states for the purpose of promoting continuity of patient care."

We appreciate LaHIE's future capability as a potential vehicle for timely and accurate information transfer for members transitioning to a new health plan, delivery system or program. In several other states, we have secured participation agreements with exchanges to use HIE data for treatment use. The use of referral data is highly effective at managing care across the continuum. The ability to schedule referral appointments, confirm the dates and share care continuity documents, e.g., progress notes between specialists and primary care, enhances care navigation and completeness.

We have worked with other HIEs nationally to establish payer/insurer data sharing policies and procedures for improving care coordination using electronic health record (EHR) exchange between provider practices, the HIE and the health plans. Laying the right foundation for data exchange elements is essential to care coordination. Having an effective and well-thought out data acquisition strategy from hospitals and clinics is critical to establishing care coordination in the community.

Coordinating Disease Management and Case Management Programs

Population Health focuses on the distribution of health and the health outcomes within a group of individuals such as Medicaid members with a goal of eliminating health disparities among the groups that are caused by social determinants of health such as socioeconomic factors that impact the health of the population. Within population health disease and case management programs are used to deliver services, education, and resources to impact the overall health of individuals.

Our case managers, experienced nurses and social workers, coordinate the care and services our members need to manage a disease or medical/behavioral health conditions. Case managers work with members and PCPs to help members access person-centered, fully integrated chronic care management, disease and case management programs to achieve member goals for health and wellness.

A member's assigned case manager assumes sole responsibility for coordinating all necessary care across the spectrum of services. The case manager remains the same, whenever possible, so that a strong relationship can develop between the member and the case manager. Our case managers assist members by:

- Educating eligible members on the benefits of case management programs
- Connecting members to PCPs, specialists or urgent care facilities, as necessary
- Making medical appointments

- Removing barriers, e.g., transportation
- Teaching self-management skills
- Arranging medical supplies and home health care, as needed
- Linking members to community resources and support
- Educating members and linking them to information and resources that will help members achieve their personal goals, e.g., resources to quit smoking

Individuals may move between lower levels of care to more intense case management programs over time as their needs, preferences and the severity of their condition or conditions changes. Our clinical management system facilitates information sharing between care team members. In addition, we conduct weekly joint complex case rounds. Chief medical officer, Dr. Ann Kay Logarbo, inpatient medical director Dr. Ordoyne, medical management manager Ms. Rintala, case managers and other members of the interdisciplinary care team who are experts in medical, behavioral health and social support areas collectively meet to review and update individual plans of care and make adjustments in the member's recommended services.

Coordinating Our Case Management Services with PCPs

Care managers are assigned to specific geographical areas and to specific providers (including ACCs) within those areas. Care managers become a trusted part of the member's interdisciplinary care team and are accessible to providers and members to help with medical, social, environmental and behavioral health issues. To coordinate case management services with the PCP, we:

- Inform providers of a member's case management program acceptance.
- Convene an interdisciplinary care team meeting to gather information on the member's history and health care needs and to solicit provider input into the plan of care.
- Actively engage PCPs in case management planning and ongoing monitoring, through telephone calls and periodic updates to the member's case management plan, e.g., changes in services or medications.
- Contact PCPs, typically by telephone, mail or fax, to monitor the member's progress with respect to the member's plan of care, obtain updates from the provider on any changes in the member's needs and solicit feedback on any changes required. For members who may not be progressing according to expectations, Dr. Logarbo may initiate more in-depth discussions with the PCP to strategize on potential solutions.
- Analyze claims/utilization data on an ongoing basis to detect variances from evidence-based medicine guidelines. When such variances are detected, a letter is sent to the member's PCP, noting this discrepancy and providing literature regarding the guidelines relative to the member's condition.
- Emphasize the importance of the PCP as a medical home in our interactions with providers, while encouraging members to communicate openly and regularly with their PCPs.
- Provide technology solutions, e.g., provider portal, Population Registry, BayouCare and BayouCloud, which facilitate efficient case management activities.
- Provide case management reports, listed below in the next subsection, to providers serving members in case management programs (per RFP section 6.38 requirements).

- Give providers access to Healthify, our community resource database to help provider staff connect members to available local and statewide resources.

BayouCare Platform

Our BayouCare Platform (planned for implementation in Louisiana in early 2015) supports community-based collaborative person-centered, integrated care for members. It is a HIPAA-compliant, secure, cloud-based health care record and information sharing system that provides comprehensive supports for the continuum of integrated, person-centered care management. BayouCare provides a mechanism to share the critical, relevant and timely member information essential to conducting ongoing care planning, management and coordination across a continuum of services and settings. BayouCare seeks to redress health disparities by providing real-time coordination among multiple providers in different physical and behavioral health care settings (e.g., social and family support for the specific populations).

BayouCare will enable clinicians to **develop and share plans** of care and co-manage high-risk patients requiring multiple specialists and caregivers. The platform design supports care team collaboration by sharing care continuity documents and progress notes though Health Information Service Provider (HISP)/DIRECT. It also supports a multiplicity of assessments that trigger care events in the plan of care and facilitates alerts to other members of the care team. BayouCare integrates evidence-based medicine (EBM) gaps in care and hospital ADT messaging available to UnitedHealthcare through LaHIE.

Our BayouCare platform's person-centric, shared, dynamic, coordinated, interdisciplinary plan of care provides a comprehensive, electronic view of the relevant issues and care needs to support the member's optimal health and achievement of health care goals. With member consent, interdisciplinary care team members have online access to the member's plan of care and can add, change or update issues, interventions and status, thereby providing timely and thorough communication for the whole team. Using BayouCare while maintaining our structured clinical care coordination and case management processes, the interdisciplinary care team can conduct assessments of a member's needs. By applying measureable, evidence-based best practices, the team can create, review and contribute to the plan of care that meets those needs.

BayouCare tracks a member's care preferences, prioritized health concerns, issues, intervention strategies, self-sufficiency goals, how well the member understands and is adhering to the goals and progress assessments. It contains member and integrated care team contact information and maintains each member's condition list, medications, service dates and outcomes, history, provider visits, diagnoses, issues, progress notes and case conference notes, lab results, gaps in care and medication adherence.

It supports ongoing care planning, management and coordination across a continuum of services and settings and supports collaboration among the interdisciplinary care team by monitoring, tracking and securely exchanging all member health care engagements, care needs, preferences and documentation. The interdisciplinary care team can track the member's progress online against the plan of care using several key features, such as an audit log highlighting updates and changes to the plan of care, filtering by particular domains (e.g., mental health), alerting based upon updates or changes and member input.

BayouCloud Portal

The BayouCloud portal is our next evolution of our online tools, where new features and functions will be added that will streamline processes and reduce administrative burdens on providers. Cost savings are achieved through greater use of self-service capabilities for providers and reduction of common work tasks (including those associated with developing and updating the plan of care) historically requiring internal manual effort.

This cloud-based real-time solution is the cornerstone of our goal to provide a single provider platform to bring together multiple websites and both administrative and clinical applications to simplify transactions. With access to the BayouCloud 24 hours a day, seven days a week, provider offices conduct business with UnitedHealthcare when it is convenient for them. BayouCloud features to be implemented over the life of the contract include:

- ***Community Collaboration for Care Planning:*** Creates online communities of providers and caregivers across the member's continuum of care in a secure messaging environment.
- ***Claims Management:*** Includes claims search detail (payment/check info, edits, codes and line level payment), clean claim status remark codes, and additional reporting features to assist in account reconciliation. Provider offices will manage their accounts receivable with greater ease due to more detailed information being provided.
- ***Claims Reconsiderations:*** Allows registered users of BayouCloud to submit claim reconsiderations with attachments and can view the status of each reconsideration submission.
- ***Enhanced Online Authorizations:*** Allows providers to submit attachments for prior-authorization requests.
- ***Clinical Portal:*** Links our integrated care model tools into a single platform with single sign on capabilities with our Population Registry, BayouCare platform and Automated Care Transitions (*UHCTransitions*) tools.
- ***Electronic Health Record (EHR) Data Sharing:*** Shares clinical information from provider's EHR through secure messaging.
- ***eConsult:*** Enables PCPs to consult remotely and conveniently with specialists to improve health outcomes for members. This tool has successfully reduced the need for face-to-face office visits by facilitating efficient and secure exchange of health information and by providing increased access to specialty care through PCP to specialist rounding on members
- ***Proprietary Systems:*** Various UnitedHealthcare portals, including single sign-on for *unitedhealthcareonline.com*

BayouCloud technology allows providers to submit attachments of required clinical documentation for prior authorizations. It also confirms that clinical information has successfully been attached to the request once the clinical information is uploaded by the provider. All attachments from the provider are posted directly into our document management application with an appropriate case identifier used internally to manage the member. A task indicates to the prior authorization team that the information is available for review in the document management application.

The BayouCloud portal is integrated with the same CSP Facets platform and systems as our portals and member advocate tools, so any stakeholder involved, whether it is the provider, prior authorization personnel, member, member advocate or our clinical team, can have visibility into the status of a case.

Using BayouCloud's messaging capability, providers and UnitedHealthcare staff will have the ability to communicate back and forth electronically and exchange information/documents with minimal delay. BayouCloud facilitates back-and-forth conversation in an easy-to-use format, and it date/time stamps and tracks when a message is sent and when a message is opened and reviewed by the receiving person. It alerts our user when an electronic message has not been opened and reviewed by the provider within a certain timeframe, so we can initiate proactive outreach.

Reporting for PCPs and Specialists

We create the following reports for providers serving members in the case management program:

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

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

Community Resource Database - Healthify

The community partnerships we have in place and continue to build are vital in helping us compile a comprehensive database of community resources our case managers can tap into to support members. Our Healthify database helps case managers and community health workers discuss needed community supports and services with the PCP. Community health workers use

Healthify to connect members to available community resources. Healthify is accessible to all of our staff who work directly with members.

Incorporating Provider Input into Strategies to Influence Member Behavior

Case management is most effective when it is closely integrated with care delivered by the member's PCP and other treating providers. We engage providers as part of the member's care team as individual members are assigned to a provider's panel. All of our network providers receive information and training during provider orientation on how to work with our case managers, members, members' families and other providers to develop, implement and coordinate individualized plans of care for our members. Case management is key to provider engagement and can be facilitated by:

- Seeking provider input about our case management and CCMP programs
- Accepting provider referrals
- Providing access to clinically valuable member information (with member consent), including pharmacy fills, diagnoses, recent health care service utilization, etc.
- Provider CAHPS/satisfaction surveys
- Direct contact with case managers, Dr. Logarbo and other UnitedHealthcare staff

We have three local provider advocates, Dana Fisher, Melissa Chambers and Tracey Guidroz, who maintain close collaboration with provider services manager Monica Thurmond. This team typically meets with Ms. Thurmond on a weekly basis, along with representatives from several other departments to discuss timely issues and items that have an impact on network providers. With a clearly defined territory and provider assignments, provider advocates spend most of their work time in the field, meeting with key providers to build relationships, answer questions and identify areas for improvement. They visit key primary care sites on a weekly basis and all sites on a regular basis.

As the link between provider and member is established, we involve the provider in the plan of care development process and assist them in directing the course of treatment in accordance with evidence-based clinical guidelines. The member's PCP has a critical role in our member outreach, member education and case management programs, and therefore, his or her input is essential to our strategies to influence member behavior. The PCP is involved in the member's plan of care development and the role that case management, CCMP and other programs have in meeting the member's goals. Acting as a bridge, the PCP often balances care between case management and CCMP. We leverage provider input to influence the member behavior.

Provider engagement plays a vital role in provider satisfaction. For that reason, we invest substantial effort in establishing and maintaining strong relationships with the provider community. We actively encourage PCPs and other providers to offer input regarding best practices to influence a member's behavior and process for accepting responsibility for their condition and health status. PCPs often know the triggers that motivate a member's behaviors and can provide meaningful recommendations and ideas. We offer several approaches that enable providers to provide direct input. These approaches include:

Collaboration with Providers: The case manager collaborates with the member's PCP on an ongoing basis to ensure integration of physical and behavioral health issues. Case managers seek provider input about member progress and strategies to improve member care. The case manager encourages providers to view and change the plan of care to drive improved health outcomes, to

note goals accomplished and document new issues or diagnoses. The case manager may consult with providers and/or ACC nurses when gaps in care are noted through data analysis or upon notification of an ER visit or inpatient admission through the Population Registry.

As the member's medical home, the PCP is an integral part of the process, facilitating member engagement with plan of care and helping to avoid unscheduled hospital admissions and ER visits. We inform providers when we enroll members in the CCMP or other case management programs and let providers know how to contact the member's case manager. In addition, the provider receives notification of members who have generated care opportunities related to specific chronic conditions.

Interdisciplinary Care Team: The case manager convenes a member-specific interdisciplinary care team to get feedback and recommendations for person-centered care and services. The interdisciplinary care team provides a forum to communicate with all treating providers as appropriate throughout the care planning process, such as when assisting with appointments, addressing questions about a member's care, monitoring a member's progress and sharing evidence-based clinical practice guidelines as appropriate.

Weekly Joint Rounds: We conduct weekly integrated joint rounds with our case management staff, Dr. Logarbo, Dr. Ordoyne, interim behavioral health medical director Dr. Charles Freed, Ms. Rintala and other members of the interdisciplinary team to review our most vulnerable, high-risk members.

Quarterly Provider Meetings: Dr. Logarbo and chief executive officer April Golenor, attend quarterly provider meetings along with our provider advocates, where they solicit provider feedback, discuss HEDIS outcomes, educate providers on our quality programs, share utilization data and discuss utilization patterns.

Accountable Care Community Program: We engage providers in our ACC program where we provide staff (community nurses and transformation consultants) and advanced technology, strengthening the provider's ability to provide care and influence member behavior. Case managers may be co-located at high-volume physician practice sites, promoting close coordination between case managers and PCPs, promoting person-centered care.

K.2 Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid MCO members.

Describe how you will leverage existing state and local resources to support health and wellness of your members including but not limited to:

- Strategies you will use to work with the Louisiana Office of Public Health to utilize existing capacity in the state for services, outreach or education. Include models you have used in other states that are in partnership or utilize a state's public health infrastructure.
- Strategies to utilized faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services (5 points)

Strategies Used to Influence Member Behavior

We use a number of strategies and tools to help us influence member behavior, including:

- Member readiness tools based upon the Transtheoretical Model of Change and Inductive Call Anatomy
- Value-added programs
- Universal Tracking Database
- Involvement of the PCP, family and community-based organizations
- Gaps in care notifications
- Other strategies

It takes time and effort to build a trusting relationship with members so that we can influence member behavior. This is why we make every attempt to keep the same case manager assigned to the member throughout the member's enrollment in case management and CCMP programs. A trusting relationship, built through consistent contact and engagement with a member, fosters member engagement with testing and treatment regimens and behavior changes that lead to improved health over time. The case manager and the member celebrate small and large successes and work hard together to solve problems when challenges or set backs are encountered. Over time, they become a team working toward the same goal along with the physician and member's family.

The Transtheoretical Model (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992) is an integrative, biopsychosocial model to conceptualize the process of intentional behavior change. Whereas other models of behavior change focus exclusively on certain dimensions of change (e.g., theories focusing mainly on social or biological influences), this model seeks to include and integrate key constructs from other theories into a comprehensive theory of change that can be applied to a variety of behaviors, populations, and settings (e.g., treatment settings, prevention and policy-making settings, etc.)—hence, the name Transtheoretical.

Member Readiness Tools

We use readiness development tools to assess member engagement and to attune our approach to encourage member participation. We use this assessment to enhance our approach and to engage members at the point that matches their readiness for change. The ultimate goal is to help support members in making positive health and wellness choices.

Transtheoretical Model of Change

We use Prochaska's Transtheoretical Model of Change concepts to assess the member's level of readiness to make the changes needed to improve health. This model dictates that, to be a positive and effective force in the member's life, the case manager must "meet the member where he or she is right now" rather than trying to push them to make changes the member is not ready for and will not yet accept. The member's state of readiness is tracked in the plan of care. Case management staff documents the current status of each member within the continuum of change to ensure appropriate care team interactions are matched to the member's engagement level.

Stages of Change

"This year I'm going to lose weight." "I'll quit smoking next month." Members may already know that certain lifestyle changes are good for their health, but they may not realize how difficult it can be to follow through with a decision. Unexpected roadblocks may get in the way, such as lack of family support or self-confidence. Researchers have discovered that most people follow a similar pattern when making transitions.

Studies show success is more likely if a member moves through the following stages one step at a time:

- ***Pre-contemplation:*** At this point, a member has not decided to make a healthy change. The member may not have all the information he or she needs to weigh his or her options. Or, the member may be hesitant because he or she was unsuccessful the last time he or she tried. To move the member forward, case managers and providers help members think about how changing habits will benefit quality of life.
- ***Contemplation:*** In this stage, it is common to put off making a decision. The member is not quite ready to commit. But, he or she may consider it a possibility in six months. When the member is stuck here, evaluating the pros and cons of the change can help the member take the next step.
- ***Preparation:*** Change is on the horizon. The member wants his or her transition to begin in the near future. The member is thinking about the best ways to help that happen. The member shares his or her goals with the case manager and PCP who can provide tips for following through with a positive health decision, e.g., it is time to quit smoking.
- ***Action:*** It is time to make a change. The member sets a goal that he or she is working toward for the next six months. Occasionally, the member may suffer a setback. The PCP and case manager can help the member stay positive and provide encouragement.
- ***Maintenance:*** The member has kept with his or her program for at least six months—a huge milestone. Setbacks are less likely to occur, but members should continue to avoid temptation, reward themselves for success and, look ahead to a healthier future.

Inductive Call Anatomy

Inductive call anatomy is a member readiness tool used to engage members. This strategy trains our staff to listen carefully, strategize with the member and support member efforts on every step of their journey to accomplish health and wellness goals. These strategies are important components of motivational interviewing—a key skill set used by our case managers to influence member behavior.

Value-Added Programs

Taking the time to understand the member's point of view can help our case managers link members to services and programs that directly address individual member needs. In addition to using member convenience motivators, such as same-day visits with providers and urgent care centers, our proposed valued-added benefits align with DHH's population health priorities. The following member programs are offered to Bayou Health members to reinforce healthy behaviors:

Reduction in Emergency Department Use

- Adult unlimited visits to in-network primary care physicians and specialists
- Adult well-visit incentive
- Well-child visit incentive
- Health risk assessment completion incentive
- Certified asthma educator home visit

Improved Birth Outcomes

- Baby Blocks
- Healthy Pregnancy Care Book

Reduction in Obesity

- Weight Watchers
- JOIN for ME Childhood Obesity Program
- Recreation program

Reduction in Health Disparities

- Community health worker
- Cell phones for high-risk members

Expanded Benefits

- Adult immunizations
- Adult dental benefit
- Adult vision benefit
- Pain Management for Adults

Additional Health, Safety and Hygiene

- Diabetic screening initiative

We coach and encourage members to live as healthy a lifestyle as possible. Telephonic and mail-based health coaching topics include:

- Nutrition
- Exercise
- Stress
- Weight management
- Tobacco cessation
- Heart healthy lifestyle
- Diabetes lifestyle

Our case managers celebrate small successes and large accomplishments with members and recognize achievement for members who attain plan of care goals. In addition, our NurseLine and case managers can help support member decision making regarding medical procedures and recommended medications. Our goal is to get members to the right care, at the right time, in the right setting.

Universal Tracking Database

Our Universal Tracking Database (UTD) is a Web-based tool used by our staff to document and track preventive outreach activities to members and providers using HEDIS specific criteria. The UTD system allows search capability by family link, so that the care manager can educate the entire family on available preventive services, such as EPSDT services, well-child visits, cancer screenings and adult wellness. This system is claims based, and reporting is available to track and trend those members receiving education on the different measures as well as to track

whether the service was obtained within 60 days of education. UTD uses HEDIS-specific criteria including:

- Lead screening
- Well child visits
- Lead screenings in children
- Immunizations
- Annual dental exams
- Chlamydia screening for women
- Breast cancer screening
- Cervical cancer screening
- Comprehensive diabetes care
- Use of appropriate medications for individuals with asthma
- Colorectal cancer screening
- Cholesterol screening
- Controlling high blood pressure
- Glaucoma screening

Upgrades to the system will soon allow ER tracking and education and State-specific elements to be added to the tool to encourage and monitor receipt of health and wellness services.

Involvement of the Primary Care Provider and Family

A strong relationship between the member and his or her PCP and case manager is beneficial to the member. The member's PCP has a strong influence on member behavior change, and the case manager works to coordinate closely with the designated PCP when developing and updating the plan of care over time. We invite PCPs to submit updates to the plan of care. In addition, our case managers often work with members and their family members in development of the plan of care to encourage positive behavior changes in support of the member's health and wellness goals.

Gaps in Care Notifications

We analyze claims and utilization data on an ongoing basis to detect variances from evidence-based medicine guidelines. When such variances are detected, a letter is sent to the member and the physician noting this discrepancy and reinforcing the guidelines to be followed. These letters are followed up telephonically with the member to reinforce the benefits of following evidence-based medicine recommendations in improving overall health over time.

Other Strategies

Other methods to influence member behavior include:

- Assign members to an ACC practice
- Health and wellness outreach materials and targeted member outreach
- Partnerships with community and faith-based organizations
- Partnership with the NowClinic, expanding member access to care in rural locations and for urgent care (subject to approval by DHH)
- Promotion of wellness, healthy lifestyles, and emergency preparedness through technology (e.g., mobile apps)
- HEDIS-related activities promoting screening services and vaccinations
- Continuity of services program to remind and educate members about the need to renew their coverage
- Programs focused on conditions prevalent in high-risk members, e.g., asthma, obesity, high-risk pregnancy, sickle cell disease and inappropriate use of ERs

Examples of Experience with Strategies to Influence Medicaid/CHIP Member Behavior

While there is always some degree of customization to meet state specific needs, we use most of the strategies listed above in our programs in other states where we operate Medicaid managed care plans. In addition to the work we have done in Bayou Health since 2012, we manage Medicaid programs in the following states where influencing member behavior is key to positive health outcomes:

Tennessee TennCare

Medicaid Population served: LTSS, TANF, children, pregnant women, aged and individuals with disabilities

TennCare Medicaid 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 services include inpatient hospital, physician, outpatient hospital, ambulance, physical therapy, nursing care, speech therapy, DME, home health care, hospice, hearing, vision, long-term services and supports (LTSS), behavioral health and non-emergency transportation.

We have operated in Tennessee since 2007 and through a fully integrated medical and behavioral health managed care population health model we have shifted service dollars from highly restrictive levels of care to less restrictive outpatient services and supports. For example, on-site assessments leading to development of in-home and community-based support services have reduced utilization of youth placement in residential treatment facilities. Thirty-four percent of youth and adults receiving on-site assessment/care coordination prior to authorization of residential treatment services were maintained at home with support services rather than being admitted to residential care. To influence TennCare members and engage them in their care, we use all of the strategies listed above in addition to health homes that specialize in specific conditions, e.g., high-risk pregnancy and behavioral health.

New Mexico Centennial Care

Medicaid Population served: Centennial Care is a fully integrated health plan that supports Medicaid and dual-eligible special needs populations.

For Centennial Care, to move members toward a healthy lifestyle, our service delivery model increases use of promotoras, community health workers and community health representatives. We recognize and value the skills they have to reach members, establish relationships, facilitate inclusion of the care coordinator, maintain the connection and facilitate services. Through strong relationships with the community health representatives in tribal communities, we continue to build new relationships that guide members to self-care and personal responsibility. We build a dialogue with community health workers and community health representatives and coordinate with them for feedback and assistance with members. We have successfully used promotoras with federally qualified health center (FHQC) partners to reduce admissions through outreach to high-risk members in need of proactive care.

Leveraging Existing State and Local Resources to Support Health/Wellness

We have established processes to leverage existing state and local resources to support the health and wellness of our Bayou Health members, particularly those members with special needs. We have a comprehensive process for ensuring seamless access to care and services across the continuum of health care services, working with varied resources, such as those supplied by government entities, faith based, social and civic groups, resident associations and other community-based organizations.

In this section, we discuss:

- How we work with the Office of Public Health (OPH) to maximize state resources in Louisiana and nationwide
- Our strategies and experience using faith-based and other community-based organizations in Louisiana

Working with Louisiana Office of Public Health Maximizes State Resources

We have experience partnering with numerous state entities nationwide. We engage regularly with OPH through the Louisiana Nurse Family Partnership, the Children with Special Health Care Needs clinics (CSHN), and the HIV Targeted Case Management program. Beverly Shields, our Louisiana-based maternal health/EPSDT coordinator, is the liaison for collaboration with the State on these entities. Through this collaboration, we work to improve the health care of these fragile subpopulations. Members can readily access information about these programs by calling our member services.

We recognize the role that local parish health clinics play in servicing the Medicaid population, including those associated with the Louisiana OPH and OPH-certified school-based health centers (SBHCs) across the State and we see the value of having these clinics in our network. **We are contracted with OPH for all of their health and family planning clinics and 60 of the 63 SBHCs to provide accessible health care to children across the State**. We will work with OPH on all public health related issues.

Experience with State Entities in Other States

We use a similar approach in our other states, where we regularly partner with state public health entities and include their OPH clinics in our network, including OPH-certified SBHCs. In addition, we have experience with state entities in the following states:

- In Tennessee, we work closely with the state entities that administer the Money Follows the Person (MFP) program to apply the MFP program accurately, assess quality metrics and provide reports, as required. Our policies and procedures include intensive care coordination, direct member support and oversight during the first year of a member's return to the community from a facility. The member's transition to the community requires more frequent home visits and contact with the MFP member than with most other LTSS home and community-based (HCBS) members. The frequency varies from weekly to monthly visits initially and then progressively lessens as the member and his or her family/caregivers gain confidence in his or her return to the community setting. We ensure adherence to MFP program guidelines, as outlined in a State's MFP operational protocol(s).
- In Delaware, one of the most important lessons we have learned is to engage pregnant moms early in the process. Working in concert with Division of Medicaid and Medical Assistance (DMMA), we take a proactive approach to enrollment outreach activities to drive members into care opportunities for themselves and their families as early as possible. This includes prenatal and postpartum outreach, outbound welcome calls to new moms and providing healthy member incentives through our Healthy Rewards program.
- Also in Delaware, through our partnership with DMMA, we have worked in collaboration with many community organizations serving Delaware's Diamond State Health Plan (DSHP) recipients to make sure children are being introduced to health-related learning opportunities at an early age, which has been shown to improve health outcomes throughout their lives. We continue our efforts to encourage members of all ages to have annual health screenings, understand the importance of healthy eating and physical activity, live in safe neighborhoods and develop the resources they need to maintain good health.

Strategies to Use Faith-Based and other Community-Based Organizations

We recognize the influence social determinates have on member health outcomes.

- One in six people lives in poverty, and research shows that each of those individuals has at least one civil legal problem that negatively affects their health.
- Five percent of the population who use health care resources account for 50 percent of the health care costs. Often this population has urgent needs for housing, coordinated care and public benefits to ensure stability, lower hospital re-admissions and improve primary care utilization.

To address these challenges, we established relationships with two startup Medical-Legal Partnerships in Louisiana as well as with the National Center for Medical-Legal Partnership. Medical-Legal Partnership (MLP) is a health care delivery model that helps vulnerable populations and individuals receive necessary legal supports and services to address the social determinants that negatively impact their health outcomes. For example, individuals living in mold or rodent-infested living conditions can have exaggerated asthma and other health conditions. If the landlord is unwilling to resolve the issues, our members will continue to seek emergent medical services and/or be hospitalized for their health condition. Therefore, it is essential to address the root causes of the health condition and the barriers to improved health in the community setting.

Including legal professionals in the health care delivery system helps to identify, intervene and resolve issues that negatively impact individual and population health outcomes. MLPs provide on-site legal resources to assist individuals referred by the treating provider. On-site legal resources reduce barriers for individuals to get the legal supports necessary to improve health outcomes. While physicians can notify the landlord of the negative impact that living conditions have on the individual, there are situations when the landlord is more responsive to legal actions. MLPs establish relationships that capitalize on the expertise of health and legal professionals and develop a team to identify, treat and prevent issues that negatively impact the health of individuals or populations. MLP partners may include hospitals, health centers, health schools, legal aid agencies, law schools and pro bono partners. While legal aid is often available to vulnerable individuals at no cost, getting to or making contact with the legal aid office often creates a barrier for the person served. MLPs are on-site at hospitals, FQHCs, schools, etc., simplifying access to needed resources.

We will continue to build upon and expand our extensive relationships and partnerships with local Louisiana faith-based, social and civic groups, resident associations and other community-based organizations, extending the reach of our health plan into the local community. We meet with key leadership of these organizations to plan meaningful programs that address persistent local needs. We listen to the challenges local organizations have faced in their efforts to improve the health of Louisiana residents and work cooperatively with them to design methods in which we can support and complement their existing efforts, e.g., fundraiser events, sponsored events, through sole and joint sponsorship of community events by locally based agencies. We have established strategic partnerships with agencies that educate, advocate and serve children and families through the following programs:

- ***Fit NOLA:*** Fit NOLA is an obesity reduction initiative focusing on obesity, a major public health challenge in New Orleans. The program challenges businesses, schools, health care organizations and government entities to commit to provide healthier food and options for physical activity in areas where people live, learn, work and play. Citizens are challenged to commit to being more nutritionally and physically fit.

Girl UP NOLA

UnitedHealthcare partnered with Girl UP NOLA, led by New Orleans First Lady Cheryl Landrieu, an initiative formed to connect New Orleans girls with positive role models and increase their access to opportunities and resources. An all-day conference hosted 75 girls in September 2013, providing lessons ranging from self-esteem to goal setting to physical fitness. A fun day of health education was provided to 15 girls and their families in August 2013, where participants were introduced to healthy food selection.

- ***ENCOREplus:*** The mission of the ENCOREplus program is to raise awareness of breast and cervical cancer and to reduce the impact of these cancers on the lives of medically underserved women in Louisiana. ENCOREplus is a community-based outreach program that provides medically underserved women with breast and cervical education, screening referral services and support services. ENCOREplus was created by the YWCA to reach out to all women who face obstacles to getting high-quality, affordable breast and cervical exams.
- ***Heart Smart Sisters™:*** Heart disease is the number one killer of women in America. More women die of cardiovascular disease than breast cancer, stroke and lung cancer combined. Heart Smart Sisters is a signature cardiovascular risk screening and intervention program that is designed to empower women to make positive changes in their lives and reduce their relative risk of developing heart disease. Through Heart Smart Sisters, UnitedHealthcare partners with organizations, businesses, churches and civic groups which share a common goal to advocate for women to become knowledgeable about heart disease prevention and the associated risk factors. The goal is to affect behavioral change through information, education and linkages to physicians and an ACC.

  The program exists to empower women to develop community-specific wellness models to support the elimination of health disparities and reduce the burden of chronic conditions that lead to heart disease. Heart Smart Sisters' four-session programs have been presented with organizations, such as Grandparents Raising Grandchildren, ExxonMobil YMCA and Catholic Charities.

- ***Together Baton Rouge:*** A coalition of more than 100 faith-based and civic groups focused on bridging religious and racial gaps as well as to help combat the increasing prevalence of blight and crime in the community. Together Baton Rouge is a broad-based coalition of institutions in the Greater Baton Rouge area with goals to build relationships across the community based on trust and a willingness to listen to each other; to equip members and leadership with skills and practices to get results; and to achieve change on concrete issues, as part of a common call to justice.
- ***JOIN for ME Obesity Program:*** A community-based childhood obesity lifestyle-intervention program. This evidence-based program, engaging the entire family, has become a national model to meet the critical need for effective, accessible and affordable treatment for childhood obesity. In 2012, UnitedHealthcare and the Louisiana Alliance of Boys & Girls Clubs launched JOIN for ME at a Community Forum featuring distinguished panelists, including Karen DeSalvo, M.D., former City of New Orleans health commissioner and former senior health policy advisor to Mayor Mitch Landrieu.

  This forum was a call to action for the community to join forces to fight the childhood obesity epidemic that is taking a devastating toll on families, communities and the country. "Children who are overweight and obese often want to lose weight, but can't figure out how to do it," said Ann Kay Logarbo, M.D., chief medical officer. "JOIN for ME provides children with an engaging and practical solution that involves the entire

family in adopting healthy eating and activity. Often, multiple members of the family lose weight by making small changes in their daily routines."

- ***Louisiana Alliance of Boys & Girls Clubs:*** UnitedHealthcare partnered with the Louisiana Alliance of Boys & Girls Clubs to host community forums to discuss the issue of childhood obesity and the JOIN for ME program. The events brought together a cross-section of leaders to raise awareness of the childhood obesity epidemic affecting our community, our state and our country.
- ***Diabetes Prevention and Control Alliance:*** UnitedHealthcare offers a variety of solutions to support people with diabetes and pre-diabetes. The Diabetes Prevention and Control Alliance (DPCA) is a partnership with UnitedHealthcare and the YMCA. The Diabetes Prevention Program, which addresses the link between diabetes and obesity, revealed that lifestyle changes and a 5 percent weight loss can prevent or delay the onset of the disease by 58 percent.
- ***Sesame Street "Food for Thought:"*** We have partnered with Sesame Street and the Merck Company Foundation on the Food for Thought program. Food for Thought is a bilingual (English-Spanish) multimedia outreach initiative that helps families who have children between 2 and 8 years of age cope with limited access to affordable and nutritious food (also known as food insecurity). Independent research indicates that Sesame Street's *Food for Thought: Eating Well on a Budget* initiative is helping families increase their knowledge, beliefs and behaviors around nutrition. **Since 2012, we have set up 31 Sesame Street reading corners in pediatric practices across the State**.

Sesame Street: Food for Thought

Through our partnership with Sesame Street, we bring to Louisiana wellness programs, including *Sesame Street: Food for Thought,* which provides practical strategies to help families make healthier food choices and to create positive experiences involving food. With Sesame Workshop, the team set the following goals for the project:

- Assist families in achieving a healthy diet by education on nutritionally sound foods
- Support caregivers facing economic challenges as they encourage children to eat healthy foods, be physically active and model these behaviors
- Provide resources that allow both children and adults to make healthy food choices

- ***Sesame Street "Lead Away:"*** UnitedHealthcare teams up with Sesame Street to offer community-based education to help parents and children learn that having children's blood tested for lead is crucial, as it is the only way to detect lead poisoning. Additionally, through simple actions, families can avoid exposure to lead and can easily incorporate prevention strategies into everyday routines. The program contains a toolkit with numerous resources, information and components to educate parents and children on the issue of lead and ways to avoid being exposed.
- ***Sesame Street "A is for Asthma Sesame:"*** UnitedHealthcare teams up with Sesame Street to offer community-based education to help children with asthma lead fun and active lives. A is for Asthma's resources are geared toward both children and adults, showing children with asthma what to do when they have trouble breathing, and explaining to the adults in their lives what they can do to help. The materials encourage

parents and caregivers to work with their child and their doctor to help the child maintain an active lifestyle.

- ***4-H "Eat 4 Health Program:"*** Nationally, we partnered with the 4-H Council and nine State Cooperative Extension 4-H programs, including Louisiana, to engage youth and their families in 4-H Healthy Living through the Eat4-Health national initiative. **Grants of $30,000 each were awarded to 4-H programs to host Eat4-Health healthy living events** focusing on building healthier communities through nutrition education and targeting at-risk and underserved populations. Louisiana 4-H reached 7,211 youth and families through summer camps, the Louisiana State Fair and other statewide healthy living events and activities.

4-H Partnerships for Healthy Living

We are proud to partner with 4-H. Together, we are empowering youth to tackle childhood obesity through individual and community change in nine states, including Louisiana, Arizona, Florida, Mississippi, Nebraska, New York, Tennessee, Texas and Wisconsin. We have experienced the following positive results in the nine states:

- 83,000 youth and families reached with Healthy Living messages last year.
- 300,000,000+ positive media impressions per year from 70+ news outlets in participating markets.
- Survey results indicate more than 90 percent of youth educated plan to drink less sugary drinks and eat fewer high fat foods, while planning to drink more water and milk and eat more fruits and vegetables.

- ***HEROES Program:*** A wellness initiative developed by UnitedHealthcare and Youth Service America designed to encourage young people, working with educators and youth leaders, to implement walking, running or hiking programs that decrease childhood obesity. UnitedHealthcare recently awarded UnitedHealthcare Heroes grants to several Louisiana schools and community-based nonprofit organizations to help children develop programs that will motivate their peers to "Step into Service." Grants of up to $1,000 each were bestowed upon youth-led programs that include a physical activity and a service component to increase awareness of childhood obesity.
- ***Cooperative Planning and Presentations:*** UnitedHealthcare provides year-round collaborative efforts and partnerships with numerous faith-based and community-based organizations throughout Louisiana. The goal is to engage with as many partners who share a common focus in delivering impactful and beneficial health and wellness results. UnitedHealthcare offers numerous presentations available to organizations, schools, non-profits, health centers, civic and community partners, and others.
- ***Volunteering and Volunteer Matching Funds:*** For UnitedHealthcare employees, the business goals and social mission are one and the same - to help people live healthier lives and modernize the health care system. We believe it is necessary to be active and responsible citizens in communities where we live and work around the world. Volunteering plays a vital role in our mission, leveraging our greatest asset--our people--as we work together to build healthier communities.

  Our Volunteer Program, known as Involve, is a one-stop shop for all things volunteering at UnitedHealthcare. Through Involve, we are creating new ways to volunteer, making it easier and more fun to make a difference. We have built incentive and volunteer matching programs, as well as, investing in new technologies to make volunteering more

accessible to everyone. **From 2011 through 2013, our Louisiana-based employees have logged over 5,300 hours of volunteer service**.

- ***Community Grants:*** In 2014, UnitedHealthcare invited statewide community and faith-based organizations, non-profits and others that work on the issue of teen pregnancy (e.g., Big Brothers Big Sisters of NELA, Caring to Love Ministries, Delhi Hospital, the Louisiana Department of Children & Family Services and DHH to a brainstorming session in Northeastern Louisiana that discussed ideas, issues and ways to ensure pregnant teens experience healthy pregnancies. On September 26, 2014, we will continue this brainstorming session, in partnership with Children's Coalition of NE LA in Monroe, with young women who are currently pregnant or recently gave birth. The purpose is to understand their perspectives and their own hopes, dreams and challenges. We will use these insights to develop a grant opportunities for community-based organizations to develop programs that improve perinatal outcomes.

Figure 15. Sharing ideas on improving birth outcomes in Louisiana during a recent community brainstorming session on teen pregnancy.

- ***Women's Health Initiatives:*** To assist in educating the community on the unique health issues of women, UnitedHealthcare was instrumental in the development of the Louisiana Center for Health Equity's (LCHE) Women's Health Retreat. Retreats have been held in New Orleans, Baton Rouge, and Shreveport. In 2012, UnitedHealthcare was recognized by LCHE as Corporate Partner of the Year for efforts to help eliminate health disparities in the State. Also in 2012, UnitedHealthcare began an annual tradition of honoring remarkable women making a difference in the greater New Orleans area with Phenomenal Woman of the Year Award. In 2013, UnitedHealthcare formed our Women's Health Advisory Council, assembling more than a dozen thought leaders for an extensive discussion of women's health issues and community needs.

March of Dimes Sponsorship

Our Bayou Health sponsorship of the March of Dimes Community Healthy Baby Shower program has enabled us to reach numerous expectant mothers, new mothers and their support systems to educate and raise awareness of prenatal and postpartum care.

- ***School-based Events:*** We team up with schools to offer health and resource fairs as well as other events. Since the implementation of the Bayou Health program, our outreach team has been involved in more than **300 events in Louisiana**, conducting back-to-school supply drives, bullying prevention seminars and summer camps that support health education in schools and reaching more than 50,000 children.

Other Community Resources

These programs complement many of the other community resources listed in our Healthify community resources database. Our community health workers promote education and outreach activities and connect our members to no or low cost resources in the community, e.g., Supplemental Nutrition Assistance Program (SNAP) or Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and those available from local affiliations, e.g., American Heart Association and the March of Dimes.

Section L: Member Transition

L.1 Describe how you will coordinate transition of a member in the following scenarios to minimize member disruption and ensure continuity of care:

- From one managed care entity to another (receiving and relinquishing a member); and
- Between fee-or-service to/from your MCO.

Your processes should address interactions with and processes for engaging existing providers in the transition (10 points)

We agree to comply with each specification and requirement outlined in RFP sections 6.29 Care Coordination, Continuity of Care, and Care Transition; RFP sections 6.30 – 6.35 related to continuity of care; and RFP section 6.36 Care Transition.

Member Transition

Whether we are coordinating the transition of *one* member or a *large group* of members who are transferring from another MCO or from the Medicaid fee-for-service (FFS) program to UnitedHealthcare or when our members transfer to another MCO or FFS program from us, we have standard processes, scalable resources and core components to ensure a consistently smooth transition, continuity of care and continuation of medically necessary services. Regardless of scale, our approach focuses on achieving an overall consistent smooth transition with no interruption in medically necessary services for all members during the member transition period.

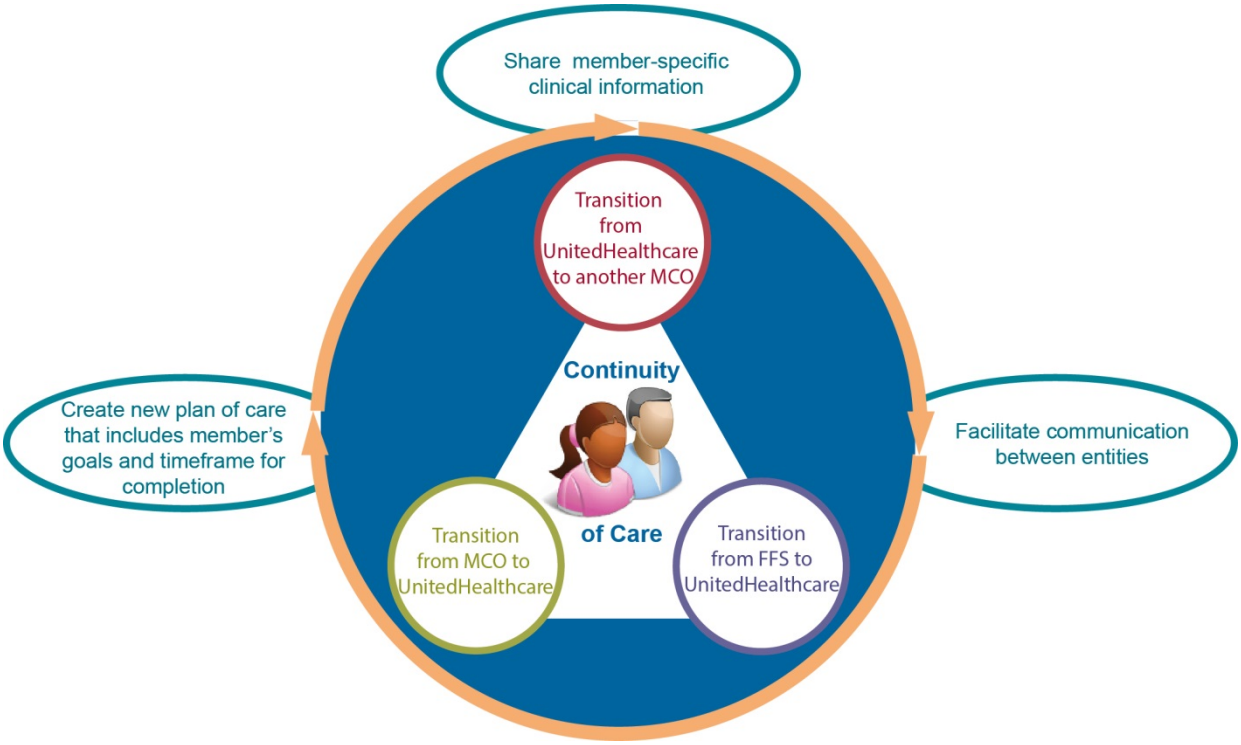


Figure 16. Member Transition. Standard processes, scalable resources and core components ensure a consistently smooth transition, continuity of care and continuation of medically necessary services.

Collaboration and coordination are required when members transition between health plans or programs, and we have successful local and national experience and expertise coordinating care

with other entities. We are fully prepared to coordinate services for members who opt into or out of UnitedHealthcare. As a member of the Louisiana Association of Health Plans, we have formed collaborative relationships with other health plan peers as well as with providers and stakeholder agencies, including DHH, school-based health centers (SBHCs), federally qualified health centers (FQHCs), rural health clinics (RHCs) juvenile justice and others to effectively deliver and coordinate care and transitions of care.

We have carefully considered our current operations and contract, including the transition of members into the Bayou Health program. What we have learned is by continually monitoring the member experience from beginning to end, we can identify specific processes and policy changes for an improved experience. For example, in a recent meeting, Susan Mieras, health plan performance manager, recommended that DHH consider including an identifier for the relinquishing MCO on the 834 enrollment file for all members transitioning from one MCO to another. This enhancement would expedite the information sharing process between the relinquishing and receiving MCOs as well as allow MCOs to conduct proactive outreach to members and providers in a much shorter time period. We recently made a similar request to the state of Tennessee's Bureau of TennCare who agreed to add this information to their 834 file beginning in January 2015.

We have worked hard to establish credibility with key Bayou Health stakeholders and have in place an experienced and talented staff who know DHH, the providers and community-based organizations and, above all, who are committed to improving the health and well-being of Louisiana Medicaid recipients statewide. Medical management manager Linda Rintala, RN, is our primary contact for member transitions into or out of our health plan. Ms. Rintala reports directly to chief executive officer April Golenor, who is wholly accountable for UnitedHealthcare's performance in Louisiana.

New Members Transferring into UnitedHealthcare from another MCO or FFS Program

We have worked diligently to fine tune our approach to coordination of care during member transitions so that we can achieve a seamless transition experience for all of our Bayou Health members, ensuring they experience no interruption in services or care as well as continuity of care. Through our experience, we have incorporated core components, described below, as necessary to achieve a successful transition of care for members transitioning to UnitedHealthcare from another Bayou Health plan or from the Medicaid FFS program. The following process flow provides an overview of our member transition process:

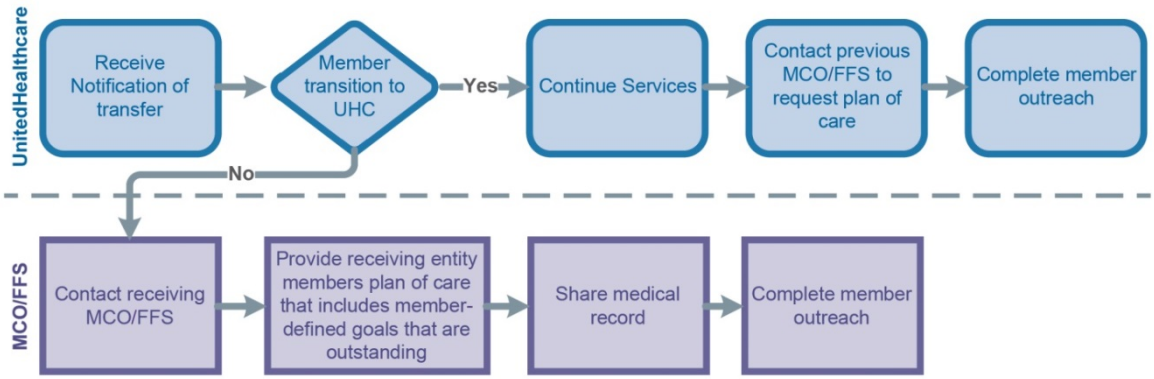


Figure 17. Member Transition Process Flow. We have incorporated core components to achieve a successful member transition into UnitedHealthcare from another MCO or FFS program.

Our goal when a member transitions into our program is to contact them early and often to establish relationships and assuage any concerns about the program change. To ensure a consistently smooth transition and continuation of medically necessary services, we:

- Conduct welcome calls to all new members and begin needs assessments with our health risk assessment (HRA) referring our most vulnerable members (high-risk/members with special needs) to a case manager for a comprehensive health status assessment (CHSA) and member education. During the HRA we ensure the member has an active PCP and encourage members to join an Accountable Care Community (ACC) by educating them about its benefits.
- Review available transitional claims and authorization data for new members; review predictive modeling analysis using claims data from DHH (during implementation and on an ongoing basis for members transitioning to us) identifying high risk members and members with special health care needs.
- Confirm services authorized by the relinquishing MCO/FFS and continue service authorizations for current services during the transition period or until a new service plan is established and agreed upon by the member.
- Honor existing prior and service authorizations approved while the member was enrolled in another MCO or the Medicaid FFS program in accordance with RFP requirements and timeframes.
- Authorize current plans of care during the 30-day transition period.
- Call members to reassure them that medically necessary services will continue.
- Inform providers (including PCPs) about new members especially those with special health care needs and the need to continue medically necessary services.
- Provide member and provider educational information about UnitedHealthcare, self-care and optimization of treatment, and review and update of existing courses of a member's treatment.
- Establish a relationship between the case manager (or community health worker) and high-risk members and set up face-to-face visits, if needed.
- Monitor transition volumes and resolve any escalated issues.

When members transition from another MCO or FFS program to UnitedHealthcare, our transition process includes the following components:

Establish a Command Center and Dedicated Member Care Transition Team

For large-scale transitions, we will establish a command center, located and staffed locally, so that we can monitor day-to-day operations for a successful transition. We create a dedicated local team, which is prepared to help new members transition successfully to UnitedHealthcare. This member care transition team is an interdisciplinary team that monitors members to ensure continuity of care and appropriate care. The team includes leaders from our clinical team (includes chief medical officer Dr. Ann Kay Logarbo and Ms. Rintala), behavioral health (e.g., behavioral health medical director and behavioral health coordinators), member services, pharmacy and provider network areas.

The local leadership team performs a readiness review prior to enrolling a large group of new members and takes steps to minimize disruptions in care and to ensure uninterrupted access to

medically necessary services. The readiness review evaluates the following transition-related elements:

- Network provider composition and access
- Staffing
- Marketing materials
- Capabilities of material subcontractors
- Care and case management program capabilities
- Content of provider contracts
- Member services capabilities
- Quality management/quality improvement and utilization management strategies
- Internal grievance and appeal policies and procedures
- Fraud and abuse and program integrity
- Information systems

Our member care transition team manages the review of any available clinical data, transitional claims or authorization data for new members, monitors transition volumes and resolves any escalated issues. High-priority Bayou Health population subsets include:

- Pregnant women, making sure they are quickly referred to Healthy First Steps, Baby Blocks, Text4Baby and other programs
- Individuals with significant needs, including special health care needs or complex conditions
- Individuals receiving ongoing needs (e.g., maintenance medications) or services or those who are hospitalized at the time of transition
- Individuals who received prior authorization from the relinquishing MCO or FFS contractor
- Individuals with behavioral health and chemical dependency issues

For people in these subsets, their transition plan is tailored to their specific health care needs. We review any existing plans of care and create a new plan of care based upon the member's current needs.

The member care transition team monitors our welcome strategy process, including use of the HRA, continuity of care and resolution of escalated issues. Prior to the transition period, the member care transition team may conduct daily team calls to monitor progress and to identify and expedite resolution of transition of care issues. These actions make sure individuals transitioning to us experience no disruption or delay in accessing their care and services. In addition to concerns about existing prior authorizations, members new to managed care may have concerns about their assigned PCP or benefit coverage, and they may need immediate care or case management support for an ongoing condition.

In addition to our member care transition team, our member services staff is already trained on the Louisiana community, the locations of local medical facilities and the cultural diversity of Louisiana, helping us to better assist our transitioning members. As necessary, they are informed

about large-scale member transitions and trained on the addition of any new covered benefits and services that we may offer as part of the Bayou Health program.

Our goal is to identify and mitigate transition issues prior to issues occurring. When issues do surface, our cross-functional team moves quickly to identify root causes and implement solutions. In many cases, issues are resolved within hours or days of being discovered. This solution demonstrates our commitment to resolving remaining issues as quickly as possible to meet the needs of DHH, our members and providers.

Formal Process for Clinical Information Sharing

Clinical information sharing is key to smooth member transitions. During all transitions, we use information obtained from multiple sources including two years of historic claims data provided by DHH, data from transitioning MCO/FFS contractors, information received from the members' requested medical records, and information received during the new member welcome call. Using the Population Registry, we are able to share clinical and member-specific claims data received with our network PCPs to facilitate continuous care for our new members.

Today, Bayou Health MCOs and FFS staff regularly collaborate to share information and to facilitate care for members who transfer from one entity to another. When we are notified of transitioning members, we use the information we obtain to outreach to the transitioning MCO/FFS contractor and any identified providers to obtain additional clinical information which helps us to identify and authorize ongoing care as needed, avoiding disruption in a member's treatment.

UnitedHealthcare

Checklist of requirements for transfer of care for Medicaid recipients

Date: ____ / ____ / _____

To:Legacy Medicaid
Attn:

Medicaid Recipient Name: _____ Date of Birth: _____
Medicaid ID Number: _____

In order for UnitedHealthcare's Prior Authorization Department to complete a Medical Review for this recipient, we require the following information:

- Current clinical information listing the recipient's condition at the beginning of your last approval
- Current level of services that you authorized
- Current number or hours that you authorized
- Current time period of authorization (begin and end dates)
- Name and phone number of prescribing physician
- Name and phone number of current physician (if different than prescribing physician)
- Date that the physician last evaluated the recipient
- Clinical information from the last period of service, listing the recipient's diagnoses and condition
- Level of care from the last period of service
- Copy of the most recent Plan of Care from the provider of the service

Please submit the above information within 2 Business Days of receipt of the request. Please be certain that all documents are legible.

Please contact the following if you have any questions regarding the process:

Jane Doe, RN jdoe@theMCO.com (555) 555-5555

Figure 18. Checklist. We have standardized processes for information sharing for transferring members.

As the receiving MCO, we are responsible for, but not limited to, providing notification to the new PCP of the member's enrollment in our health plan, initiating the request of transfer for the member's medical files (unless the member has already arranged for the transfer of his or her medical records), arranging medically necessary services, e.g., prenatal care, acute care, etc. (if applicable) and meeting all other requirements for transitioning members.

Relinquishing PCPs are responsible for providing needed information about a transitioning member to us on a timely basis. As such, upon notification of a member's transfer, Ms. Rintala, our primary member transition contact, makes a formal request for a copy of the transitioning member's complete medical record, case management files, plan of care, and supporting documentation and requests access to all medical information necessary to coordinate care for that member, as illustrated in the checklist for transfer of care.

Worth noting and in practice today, it is the relinquishing MCO's responsibility to ensure we receive updated information for any transitioning member. This includes assuming the cost of reproducing and forwarding medical records and case management files to us in a timely manner. The transition of records cannot interfere with or cause delay in the provision of services for the transitioning member. Therefore, Ms. Rintala makes it a priority to ensure open communication with the transitioning MCO as to what information is needed and to follow up to make sure we receive the information, including notification of pertinent information related to any special needs, on a timely basis. If we have not received the member's record within 10 business days of our request, Ms. Rintala follows up with the relinquishing MCO or PCP to resolve the issue and, as needed, escalates any issues related to receipt of member information with relinquishing health plan leadership or DHH, as appropriate.

We have and will continue to focus on the needs of these members by working closely with relinquishing MCOs to identify members who require enhanced coordination. During the information sharing and process of coordinating a new member's care and on an ongoing basis, we protect each member's privacy in accordance with the privacy requirements in 45 CFR Parts 160 and 164 and other applicable state or federal laws.

Proactive Outbound Calls Enhance the Member Welcome Experience

When members transition into UnitedHealthcare, their first experience with us may be during the new member welcome call. Members new to our health plan often have a number of common questions during the first month of enrollment, ranging from basic questions on benefit coverage to assistance with changing PCPs.

Our new member welcome team, comprising member services representatives, conducts outbound welcome calls to new members. Member services representatives are trained to understand and anticipate our new members' unique needs, e.g., need to transfer a prescription or authorization for a service currently received. Member services representatives use innovative tools and scripting to provide validated health plan information, to answer any immediate questions our new members may have about access to care or health plan-related questions and to:

- Welcome the member and verify demographic information
- Offer an overview of the member's covered benefits and services
- Promote member engagement through motivational interviewing and gather timely information to help provide personalized services
- Confirm the member's PCP assignment, discuss the importance of the PCP/member relationship, address PCP-access issues and offer to help the member change his or her PCP, if necessary
- Connect members with their PCPs by assisting with appointment scheduling and, as needed, secure transportation services for the PCP appointment
- Conduct the HRA to identify care or case management needs, offering to reschedule it for a time that is more convenient for the member, as necessary
- Discuss the member's active treatment plan and receipt of any covered, medically necessary and authorized services to ensure smooth transition and continuity of care
- Triage members to identify care or case management needs and the need for additional transitional support using an HRA

- Refer members to care or case management for a CHSA based upon the HRA score
- Discuss the importance of EPSDT screenings with members or their families and assist members who need to complete EPSDT screenings that are due or overdue
- Promote value-added services and preventive care, e.g., well checkups and dental screenings
- Review information on how to access pregnancy programs and resources, e.g., referrals to Healthy First Steps, Text4Baby and Baby Blocks, as needed.
- Review how to access carved-out services, e.g., specialty behavioral health services, dental services, personal care services, waiver services, etc.
- Document information in our clinical management system, CareOne, providing care coordinators and case managers access to up-to-date, member-specific information to facilitate the coordination process.
- Confirm the member has received written materials sent
- Educate members about covered services complemented by various other communications methods, including:
  - *Member Handbook*
  - Member newsletters
  - Member Web portal
- Inform members that our website (*uhccommunityplan.com*) is available in English and Spanish and that they have the option to print their own ID card and that they can access their benefits and claims information via the secure website (*myuhc.com*)

We make three outbound call attempts at different times of day to maximize the number of members we reach. If necessary, we can involve community health workers in local communities to help us find and engage new members and to encourage them to contact us. We serve members in their choice of primary language, and the current member services line for Bayou Health members provides six language options, including Spanish, Russian, Chinese, Vietnamese, Portuguese and Bosnian, in addition to our interpretive services resources. We actively recruit member services representatives with bilingual capabilities and extensive experience working with diverse populations and we train them to assist non-English-speaking members. We also accommodate the linguistic needs of non-English-speaking members through interpretive services, allowing us to communicate with members in any one of more than 170 languages.

Continuation of Prior Authorized Services

To ensure continuity of care for our transitioning members, we honor all prior MCO/FFS program prior authorizations by approving all payment requests for covered services without an authorization during the required transition period, thereby allowing time for appropriate review and coordination of care. We identify these prior authorized services through information received from the transitioning MCO/FFS program as well as from provider records and member outreach. We honor the authorized services regardless if the services are authorized to an out-of-network provider, in-network provider or for services that did not require a prior authorization in a FFS program but are required in our program. To prevent a lapse in care (e.g., reach out to a contractor or health plan case manager to continue a member's ongoing personal care services or specialty behavioral health services) we actively outreach to providers providing the services and

to members notifying them of the ongoing coverage. If services have been authorized to an out–of-network provider, we assist members in moving to an in-network provider or work with the provider network team to bring new providers into the network (we cannot deny a transitioning member's prior authorization solely on the basis of the provider being an out-of-network provider during transition).

To help with the transition of services, we offer members additional information in their welcome packet, which highlights actions they should take to continue prior authorized care. During our provider educational sessions, we remind providers of the importance of maintaining continuous care for transitioning members, the prior authorization process and how to receive compensation for services provided.

Once we have complete information for a member, we review all the prior authorized services and make medically necessary determinations for continuation of services based upon assessments, provider input, clinical records as well as input from the case management team and the member and family. Prior authorization determinations are made as fast as the member's condition requires and in accordance with contractual requirements. After 30 calendar days or as other specified in the contract, we may require prior authorization of services and will assist new members and providers with the necessary authorizations.

Ensuring Continuity of Care

A continuous relationship between a member and his or her PCP is a fundamental characteristic of our care model. Continuity of care can improve the quality of a member's care because the member's PCP is aware of the member's health problems and the efficacy of treatments the member has already received and because the member is more likely to call his or her PCP for medical care and advice. Skipped or delayed health care can lead to unnecessary illness or even death. It can also lead to inefficient and costly use of the ER or preventable inpatient care for medical conditions, such as asthma or diabetes. Through the transition process, we ensure that the member has selected a PCP and we notify that PCP of the member's enrollment. In addition we are able to share historical claims information with the PCP through our Patient Registry.

As the receiving MCO, we adhere to all RFP requirements for assuming responsibility for the costs of continuation of services provided by participating or non-participating providers. We offer contracts to non-contracted providers so that members who transfer into our plan can continue receiving services from the same provider. If providers do not wish to contract with us, services will continue with a contracted provider of the member's choice. Any transition to a new PCP is carefully coordinated in a manner that makes sure there are no interruptions in member's care and services.

Care Coordination and Continuation of Medically Necessary Services

We coordinate care as necessary for all members transitioning to our health plan. We focus on members who are in active treatment and who have special health care needs. Our transition process includes:

- Review of member-specific claims, case management history, released medical records, HRA data, authorization data to identify members with critical needs
- Proactive outbound calling and partnerships with critical service providers to make sure vital services are not dropped (e.g., dialysis or transportation to dialysis)

As needed, the member's case manager continues care with a member's current provider to make sure the continuity and transition of care after a member's medical condition is stable and adheres to all RFP-related continuity of care requirements with regard to prior authorizations and required timeframes for all members transitioning to UnitedHealthcare. We identify members who need to make a primary care appointment, members who need to obtain prenatal or pregnancy-related services and members with special health needs who need care coordination and support. We place special emphasis on coordinating care for individuals with complex and comorbid needs, particularly those with frequent exacerbation of chronic conditions that require high utilization of medical services, e.g., uncontrolled diabetes or asthma and behavioral health recovery services. We understand and will comply with contract terms for as well as provide additional support and care to those in the following subpopulations:

- Pregnant women
- Members with special health care needs
- Pharmacy services
- Behavioral health
- Durable medical equipment (DME), prosthetics, orthotics and certain supplies

We take the following steps to ensure continuation of medically necessary services:

Step 1: We review the clinical needs of each member, including the needs for additional or specialized services to meet the needs of a member with comorbid, serious mental illness, substance abuse or co-occurring disorders. Member transition care coordination includes consideration of the member's immediate medical, behavioral health and social needs, community resources, natural supports and other services necessary to promote the well-being of the member and make sure the member's treatment promotes positive health outcomes, inclusive of recovery and resiliency.

Step 2: We coordinate care with network or non-network providers to ensure appropriate services are available during transition and beyond. During transition, we do not deny prior authorization solely on the basis of the provider being an out-of-network provider. If a covered service is needed to support the clinical needs of a medically complex member and is not available within our network, the member's case manager arranges for accommodation through a request for the provider to join our network or through a single case agreement to a provider who has the expertise to treat the member.

Step 3: We work closely with our new members, their families and PCPs to develop an up-to-date, person-centered plan of care. The updated plan of care includes all appropriate collateral providers to address any complex issues involved. Our established clinical care criteria address treatment modalities that are effective for each diagnosis.

Step 4: To make sure members with comorbid medical and behavioral health conditions have coordination of care and integrated medical and behavioral health care, a case manager with either medical or behavioral health expertise develops the member's plan of care collaborating with and receiving input from medical and behavioral health providers and coordinates the member's care. Formal coordination processes are already in place, including participation in joint medical and behavioral clinical rounds and timely exchange of treatment information between medical and behavioral providers.

Proactive Management of Behavioral Health Populations Transferring from FFS

If the State decides to carve-in behavioral health services from FFS to managed care, we will work proactively with members and providers to ensure continuation of services by:

- Offering providers information about plan benefits, authorization and claims filing through webinars, online and other communications
- Encouraging behavioral health providers treating transitioning members to call our clinical department to obtain service authorizations
- Working with out-of-network providers rendering care to our members by asking them to join our behavioral health network or completing single case agreements, as necessary, for continuity of a member's care
- Encouraging members to contact our behavioral health clinical department to discuss transition support and to receive assurance they will be able to continue their therapeutic relationship without disruption

Previous UnitedHealthcare Experience with Transitioning Members

Our national experience, best practices and lessons learned provide evidence of our ability to transition large-scale, new member populations from FFS programs and to coordinate continuation of medically necessary services and ensure continuity of care. Our wide-ranging experience transitioning members from FFS programs includes:

- At the inception of the Bayou Health program in 2012, we successfully on-boarded more than 225,000 members during the initial enrollment period with negligible negative impact to members' existing plans of care**. The open enrollment periods of 2013 and 2014 led to our status as *MCO of choice,* ranking #1 in member selection.** This resulted in significant membership gains, again managed with negligible impact to existing plans of care.
- In Kansas in 2013, we successfully transitioned 117,000 new TANF, CHIP and ABD members, including individuals requiring long-term services and supports (LTSS) services to managed care from FFS as part of the statewide implementation of KanCare. UnitedHealthcare was one of three receiving MCOs involved in this transition of members from the FFS program. During the transition period, our members experienced no significant interruptions in authorized service plans. In most cases, authorized services continued to be delivered by the same providers. The state of Kansas and MCOs worked cooperatively to make sure care transitions caused no disruption in existing service arrangements for KanCare members.
- During the implementation of the Tennessee CHOICES program in 2010, we successfully transitioned 14,744 members from the waiver program to our CHOICES LTSS program at go-live. To ensure no interruption in services for our new CHOICES members, we confirmed with the member and the member's provider that their plan of care met the member's HCBS needs. **We conducted outreach to approximately 4,000 LTSS members to confirm their HCBS services plan of care and update the plan,** as needed.

> **"Consumers get services; providers get paid."**
> Having a strong continuity of care priority that can be easily communicated is very effective, as seen during the Tennessee CHOICES LTSS transition.

- In Florida, we successfully expanded from 15 to 67 counties when we were awarded the first Florida Healthy Kids Corporation contract. To promote a seamless process for providers and members, we created centralized transition solution teams from operations, compliance, member services, health services, pharmacy, behavioral health and provider relations to troubleshoot potential issues on a daily basis. In preparation for the transition of members from FFS to managed care, we secured the files of current members who were in active care and took the necessary steps to provide coordinated care.
- When Florida Healthy Kids Corporation carved in pharmacy benefits for 55,000 CHIP members—30,000 of those members were new to our health plan. We transitioned the members and the pharmacy benefit with no gaps in care by scaling our transition approach for a large influx of members.
- During our Arizona transition of members from FFS to managed care, the State brought together all MCOs and jointly identified key data to be shared among MCOs. This coordinated data share was needed to ensure each receiving MCO would be aware of the current clinical disposition of members as they were assigned to that MCO, so that the MCO could appropriately assign each member to the correct level of care. Specific data shared included members who were inpatient, those receiving special care (e.g., transportation needs and community-based care) and members with prior authorization for services in the new contract year.

  During this program change, UnitedHealthcare relinquished members in some counties and gained members in others, so we generated data files for receiving MCOs and received and processed data files from other MCOs for members transitioning into our health plan. This data sharing approach was successful, resulting in few service interruptions or issues regarding member continuity of care during the transition. We received high praise from the state of Arizona for participation in this process.

Relinquishing Members Who Transition Out of UnitedHealthcare

Our comprehensive care transition policies and procedures serve to reinforce our position that our members' needs come first, regardless of the member's status or the reason a member is transitioning out of UnitedHealthcare. We monitor unique situations and inform DHH, as necessary.

With the aid of a support team comprising clinical staff, Dr. Logarbo and Ms. Rintala oversee the transition of member(s) to another health plan or to a FFS program while facilitating continuity of care and ongoing services. For members transitioning to another MCO, we make it a priority to share the plan of care and other important clinical documentation, including prior authorized services with the new MCO on a timely basis. We consult with the other MCO staff and answer any questions they may have about the

Transition-out Experience in Louisiana

In 2014, medical management manager Linda Rintala worked closely with Molina Medicaid Solutions to successfully transition one of our members to the Legacy Medicaid program. To facilitate this member's continuation of services and seamless transition to the Legacy program, upon receiving the request for member-specific information, Ms. Rintala promptly provided Molina with a list of the member's approved services, including:

- Pediatric day health care
- Nonemergency transportation
- Intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, mental and psychosocial impairments

Ms. Rintala also provided Molina with detailed background information about the member.

member's care.

Our transition-out process includes:

- Identification and communication of primary contacts (UnitedHealthcare and new health plan) for coordination of phase-out strategies
- Contact between Ms. Rintala (our designated health plan transition contact person) or the member's case manager and the receiving health plan's case manager or designated contact person
- Provision of timely notification to the receiving MCO regarding pertinent information related to any special needs of transitioning members
- Member/family/caregiver involvement and input, as noted on the plan of care
- Active assistance to members when they transition to another MCO
- Information sharing of clinical history, member-defined goals (e.g., plan of care goals and accomplishments or outstanding problems/barriers) and utilization information (e.g., number of hospitalizations, ER visits, over and under-utilization)
- Medication compliance (e.g., pharmacy-related education completed or needed, as documented on the plan of care)
- Member engagement (e.g., motivation techniques used and frequency of contacts, as noted on the plan of care)
- Clinical documentation, including providers and services used, as noted on the plan of care
- For members hospitalized at or on the effective date of enrollment into the receiving plan, we maintain financial responsibility for the member's hospitalization costs until the member is discharged and support the receiving MCO in ensuring an appropriate discharge plan

Transitions of care are critical periods for our members, therefore, we work collaboratively with the new MCO or health plan to successfully transition members. While we recognize that our members with special health care needs may have the most pressing ongoing needs, our transition process is applicable and scalable for all of our transitioning members.

We remind impacted providers about the importance of care coordination through provider mailings and faxes. We remind them of DHH's goal to maintain continuity of care and provide guidance for members who may be leaving our plan.

Transition-out of incarcerated members: Transitions of care issues are particularly important for our incarcerated members and whose eligibility for our Medicaid program may fluctuate during or following incarceration. Incarcerated individuals have high rates of mental illness and substance abuse disorders, making care transitions particularly relevant for assuring they have continued access to community-based behavioral health treatment. As required by DHH, we request disenrollment of members we have identified as incarcerated. We work proactively with DHH and the receiving health plans to address our incarcerated member's whole health needs as they transition from UnitedHealthcare to another health plan or FFS program.

Clinical Information Sharing

Upon notification of a member's transfer, we make readily available a member's complete clinical record, including outpatient and inpatient utilization data, preventive health data, claims reports, pharmacy data, and all medical information necessary for the care of that member, including case management files. We share open authorizations, including those related to pharmacy and behavioral health, DME, therapies, cancer, dialysis and transplant services. This data helps our members' new MCO or health plan staff understands member-specific needs. We encourage direct communication with the new MCO and, most importantly, with the member's new case manager.

We allow the receiving MCO access to all medical information necessary for the care of that member. When relinquishing members, we provide timely notification to the receiving MCO regarding pertinent information related to any special needs of transitioning members. We manage coordination of care and discharge planning for our members who are hospitalized on the transition day. As required, we pay the cost of reproducing and forwarding medical records to the receiving MCO.

Coordination of Services and Continuity of Care

If a member or a group of members are transitioning from UnitedHealthcare, we partner with the new MCO, health plan or delivery system to support coordination of medically necessary services and continuity of care for our members. We provide the receiving MCO or health plan member-specific information related to prior authorizations and PCP and other provider assignments to facilitate continuity of care.

As needed, we can create a member support team to monitor exiting members for continuity of services and care as well as concerns, making sure we adhere to appropriate DHH guidelines and requirements and HIPAA regulations. The support team may include representation from our clinical team, behavioral health coordinators, member services, pharmacy and provider network areas. A support team can remain in place until the transition-out period is complete and the member is stable.

Members with Significant Medical Conditions or Special Health Care Needs

Our primary goal is to make sure that no gap in services occurs so the member can continue treatment in a safe and effective manner. As a relinquishing MCO, we are responsible for timely notification to the receiving MCO regarding pertinent information related to any special needs of transitioning members.

Members with special health care needs (e.g., chronic or complex conditions, external feedings, oxygen, wound care, ventilators, medical supplies, transportation on a scheduled basis, chemotherapy or radiation therapy or who are hospitalized) who are transitioning to another MCO or health plan need additional support and care. These members include individuals with frequent exacerbation of chronic conditions that require high utilization of medical services, e.g., uncontrolled diabetes or asthma and behavioral health recovery services.

Members with special needs may also include members who have conditions requiring ongoing monitoring or screening, e.g., elevated blood lead levels and members who were in the NICU after birth. We give special consideration to members with significant medical conditions, e.g., high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation and chronic illness resulting in hospitalization. We take proactive steps,

particularly with regard to information transfer, to make sure these members do not experience a disruption or delay in accessing care and services in the new plan.

Members with Ongoing Needs and Prior Authorization

We work proactively to avoid disruptions related to prior authorizations (e.g., scheduled surgeries, post-surgical follow-up visits, therapies to be provided after transition and out-of-area specialty providers). For members who are transferring to another plan and who have ongoing needs, we make available to the receiving health plan existing prior authorizations or approvals for covered services as well as utilization reports inclusive of services rendered to the member prior to the transition. We can report on authorized services for which we have data, which may or may not include services provided by contractors that provide carved out services. At the present time, we do not have claims data for specialty behavioral health services unless our member is in a shared case management arrangement.

Reports related to transition may include:

- Current open authorizations for inpatient or outpatient medical, maternity and behavioral health services (*only available if we have received claims data from the State Management Organization*)
- Current open authorizations for pharmacy (e.g., members involved in a step-therapy process are not required to start again from the beginning of the step-therapy process)
- Inpatient claims report (includes facility):
  - Acute hospital services and acute inpatient rehabilitation services
  - Skilled nursing facility services
- Outpatient claims reports, including provider name for the following services:
  - Maternity services
  - Transplants
  - Durable medical equipment and medical supplies
  - Infusion services
  - Chemotherapy treatment
  - Dialysis
  - Therapies
  - Outpatient surgery

Summary

We have standard processes, scalable resources and core components to ensure a smooth member transition, continuity of care and continuation of medically necessary services for members transitioning in or out of UnitedHealthcare. Key components include:

- Command center and member transition care team, as needed for large-scale transitions
- Clinical information sharing
- Proactive outbound calls and new member welcome process, including encouraging our new members to join an ACC
- Continuation of prior authorized services
- Continuity of care

- Care coordination and continuation of medically necessary services, including updating the member's plan of care and closing any gaps in care

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

- Encourage Members who are expectant mothers to select an MCO and PCP for their newborns;
- Ensure that newborn notification information is submitted, either by you or the hospital, to DHH or its Agent within twenty-four (24) hours of the birth of the newborn; and
- Ensure that the birth is properly recorded in the Louisiana Electronic Event Registration System (LEERS). (5 points)

Encouraging Expectant Mothers to Select a PCP for their Newborn

We recognize the need to provide newborns with immediate and consistent health care and agree to comply with each specification and requirement outlined in RFP Section 11.10.4 related to Newborn Enrollment.

We employ a broad variety of techniques to communicate with expectant mothers and provide them with support, education and information related to well-child care, including the importance of a PCP for their newborn. We will use the following methods to contact them 60 calendar days prior to their expected delivery date to encourage selection of a PCP for their newborn:

- ***Outbound reminder phone calls:*** We will make outbound calls using our auto-dialer technology to expectant mothers as a reminder to select a PCP for their newborn.
- ***Mail reminder:*** Printed reminders will be mailed to expectant mothers' homes, providing them with information on how to select a PCP for their child.
- ***Healthy First Steps:*** Healthy First Steps is our high-risk maternity case management program which provides personalized member interaction, focusing on improving birth outcomes and NICU avoidance through a multidisciplinary approach to care. We will leverage our Healthy First Steps maternity wellness program to educate mothers-to-be who are enrolled in the program about PCP selection for their baby.
- ***Healthy Baby Showers:*** Through our local outreach activities, we sponsor the March of Dimes Community Healthy Baby Showers initiative in Louisiana, providing education and encouragement to expectant mothers, new moms and their support systems. Outreach activities such as this will provide us with additional opportunities to urge PCP selection for newborns.
- ***Text4Baby:*** For expectant mothers who have signed up for the free Text4Baby program, which sends educational text messages about child care and pregnancy, we will include reminders regarding PCP selection for newborns.
- ***Twitter@UHCPregnantCare:*** Through Twitter, *@UHCPregnantCare*, our followers receive health and wellness information related to pregnancy and child birth. The Spanish version launched in January, *@UHCEmbarazada*, has the same content as *@UHCPregnantCare*. We will leverage this technology to encourage expectant mothers to select a PCP for their baby.
- ***Case Manager:*** High-risk pregnancy case management outreach to members with high-risk conditions by RN case managers will encourage and assist expectant mothers with selecting a PCP for their newborn.

- ***Community Health Worker Program:*** Our Community Health Worker program brings coordinators to local communities and the homes of members, where they are able to answer questions and provide assistance. Coordinators come directly from local neighborhoods and may direct and assist expectant mothers with choosing a PCP for their child.

If the expectant mother transitions to us while pregnant and retains a non-participating PCP, we will assist her in finding a participating PCP for the baby. If a PCP is not selected for the baby, we will auto-assign a PCP, allowing at least 14 days following the birth, via our logic-based Provider Recommendation Engine (PRE), which assists in matching members with providers who demonstrate excellence in quality. PRE leverages historical claims, family linkages and tier one PCPs. In addition to these methods, we will open discussions with non-participating PCPs about our current process to ensure that all newborns receive care.

Ensuring Newborn Notification Submission to DHH within 24 Hours

To comply with RFP Section 11.10.4.2, we will incorporate contractual requirements with network hospitals requiring them to report the births of newborns within 24 hours of birth for enrolled members using DHH's web-based Facility Notification System (FNDS) Newborn Manual. We will provide education for the hospital on this contractual requirement and develop an audit system to ensure compliance.

Recording Births Louisiana Electronic Event Registration System

To comply with RFP Section 11.10.4.3, we will incorporate contractual requirements with network hospitals requiring them to register all births through the Louisiana Electronic Event Registration System (LEERS). We will provide education for the hospitals on this contractual requirement and will develop an audit system to ensure compliance.

L.3 Describe the types of interventions you will use prior to seeking to disenroll a Member as described in an MCO-Initiated Member Disenrollment, Section 11 of this RFP. If applicable, provide an example of a case in which you have successfully intervened to avert requesting the disenrollment of a member. (5 points)

Member Disenrollment

Across all our health plans, we value our members and work diligently to demonstrate respect for their rights. Our culture is built on this foundation and we take seriously each disenrollment request. We recognize Appendix U of the RFP and understand that there are allowable reasons for seeking involuntary disenrollment, as specified in RFP Section 11.11.4.3:

- The member misuses or loans the member's MCO-issued ID card to another person to obtain services. In such case we will report the event to DHH.
- The member's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the MCO seriously impairs the organization's ability to furnish services to either the member or other members.

Interventions Used Prior to Disenrollment

The following interventions are conducted as needed.

Member Misuse or Loan of Membership ID Card

We address member misuse or loaning of ID card practices through utilization profiling, a system of identifying members who exceed normal services for certain diagnoses and other criteria.

When suspicious activity is discovered, our Fraud, Waste and Abuse (FWA) program staff applies investigative analytics to the member's claims data and a preliminary investigation is conducted. The member who is the subject of the investigation is not contacted. If the investigation does not indicate FWA, it may identify the need for member education and training. We complete the appropriate member education (e.g., informational materials about appropriate processes) in a timely manner. If the investigation determines that a member should be reported, we will notify DHH and the Medicaid Fraud Control Unit (MFCU) simultaneously. Our program has national experience and a local Louisiana presence with the ability to interact with local law enforcement.

We intend to implement our High Cost Members program for the State in 2015. This advanced detection program identifies members whose diagnoses do not appear to warrant recent claims payments made on their behalf.

Member Behaviors that Impair Abilities to Furnish Services to Member or Others

For situations when a care coordinator or case manager identify an existing and ongoing valid reason for an MCO-initiated disenrollment due to member behavior, we will take the following steps to resolve the issue with the member.

1. The care coordinator or case manager will notify the manager of case management of the issue.
2. The manager of case management will arrange a meeting with Ms. Rintala and Dr. Logarbo to review and discuss the potential for an MCO initiated disenrollment.
3. The meeting agenda will include a review of state-mandated valid versus invalid reasons as related to specific member and supportive documentation review.
4. Upon verifying a valid request to disenroll a member, we will take the following steps to resolve the issue and keep the member as part of our program:
   - Ms. Rintala will make, and document, at least three attempts to resolve any issue with the member that might lead to a potential MCO-initiated disenrollment. We will document the member's response to our resolution strategies. These three attempts will:
     - Include both education and case management strategies to resolve the issue
     - Occur over a period of 90 consecutive calendar days before we request a disenrollment (unless the member has demonstrated abusive or threatening behavior)
     - Be made at least every 30 days of the 90-day consecutive calendar period
   - Dr. Logarbo and Ms. Rintala will confer to decide if the MCO-initiated disenrollment should be pursued
5. In the unlikely event that we cannot resolve the issue with the member and we must initiate a valid MCO-initiated disenrollment, Ms. Rintala will follow the procedures and work instructions as provided by DHH in Appendix U.

Example of Successful Intervention to Avert Disenrollment

Our disenrollment intervention strategies are effective, as evidenced by the following example:

Effective Disenrollment Intervention

Through our Complex Case Management program we identified a Bayou Health member with over 80 hospital admissions in three years for Sickle Cell Disease, several of which he left against medical advice. We also identified misuse of medication therapies. Information was received to indicate the member was possibly involved in prescription fraud related to pain medication, suggesting he may have drug dependency issues. During one recent hospitalization, the member left his assigned floor with his PCA pump and was discharged due to this violation of hospital rules.

The member was unwilling to participate in our programs that were needed due to the frequency, number and reason for the hospital admissions. Over 38 unsuccessful attempts to contact the member were made by our case management staff. Attempts were also made to reach the member through collaboration with hospital discharge planning staff, transition care management nurses and behavioral health advocates. Between the possible fraudulent activity and non-compliance issues, we were eventually obligated to consider disenrollment.

However, through discussions and collaboration with DHH, we worked to identify additional opportunities to help the member and thereby avoid disenrollment. The member has been placed in the Pharmacy Lock-In program and referred to the SMO for specialized behavioral health interventions. Our hope is that he will benefit from the knowledge that his services are being monitored and seek assistance, so that we will have an opportunity to assist him in managing his illnesses.

Section M: Early Periodic Screening, Diagnosis, and Treatment

M.1 Describe your system for tracking each member's screening, diagnosis, and treatment including, at a minimum, the components of the system, the key features of each component, the use of technology, and the data sources for populating the system. (5 points)

We use broad communication strategies to inform members and their families under the age of 21 years that the EPSDT periodic screening benefit is available. We understand the importance of early identification and outreach and we expect to build on current momentum statewide to produce creative, preventive health strategies that engage members and their families in compliance with RFP Section 6.4.3, 6.6, 6.6.5 and 6.7.

EPSDT Tracking, Innovation and Technology

We continue to bring best practices and innovative programs to Bayou Health that will provide increased rigor and timeliness around our EPSDT process for eliminating gaps in care as using the unique preventive health compliance programs described below:

Key Data and Technology Components of EPSDT	**Key** Features
smartEPSDT	As a result of the EPSDT best practices that we have established in our Arizona and Hawaii Medicaid plans, we propose a new method for EPSDT monitoring and follow up for Bayou Health members. We will implement, subject to the agreement of DHH and other managed care organizations (MCOs), **a centralized, Web-based tool that will reduce the administrative burden for providers and payers, and transform care delivery by storing and reporting EPSDT data and promoting rapid and timely follow up for issues identified by EPSDT assessments.** The tool will be a delivered through BayouCloud accessible for all providers and all MCOs (as below). The tool will also improve documentation of preventive services, identify gaps in care and provide coordination between providers.
BayouCloud	We continue to pursue innovative solutions to streamline and simplify our providers' administrative experiences. Our most recent evolution of online tools is a cloud-based website, called BayouCloud. As we deploy this advanced technology solution, we are ready and willing to offer this infrastructure and expertise for any or all of its data solution components to the State and to other MCOs to enable and facilitate data sharing. For example, **to help address EPSDT data collection and reporting across the state and across the awarded MCOs**, at DHH's discretion and in cooperation with the other MCOs, we propose to create and host in our cloud infrastructure a new common repository and Web application. This tool will **enable all providers to report their EPSDT visit and referral information in a hosted interactive Web form that records services members received.** This information would then be available for all MCOs to report and conduct referral follow-ups.

Key Data and Technology Components of EPSDT	**Key** Features
Member Data Sources	***834 Eligibility Files:*** We conduct monthly reviews of 834 eligibility files for the ages of our new members as an indication of EPSDT-eligible member status. ▪ ***Enrollment Data:*** Used by member services for new member welcome calls, health risk assessments (HRAs) and ESPDT member education ▪ ***Claims and Encounter Data:*** Monitored on an ongoing basis to identify members who have failed to complete periodic screenings ▪ ***HEDIS Care Measures:*** Overall performance monitoring accomplished through EPSDT reporting and HEDIS pediatric preventive care measures
Member Engagement Tools	***Health Risk Assessment (HRA):*** The HRA captures baseline information identifying EPSDT-eligible members and triggers more in-depth assessments when needed. We also leverage this initial phone outreach to identify: ▪ Children that are already under the care of a PCP and are current with screens and immunizations ▪ Children who are due or overdue for preventive care, EPSDT screenings or immunizations ▪ Special health care needs
Clinical Practice Guidelines	Historically, the State EPSDT periodicity schedule indicated that adolescent well care was to be provided every two years as opposed to every year. Our Clinical Practice Consultant (CPC) program promoted annual visits for adolescents, which is one explanation for the improved performance. We adopted a periodicity schedule aligned with the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule that recommended annual visits as the standard of care. As a result, **we met our goal for Immunizations for Adolescents and exceeded the NCQA Quality Compass 90th percentile.**

ESPDT Accountability

As in the past, maternal child health/EPSDT coordinator Beverly Shields will bring her considerable experience and effort in the state of Louisiana to ESPDT compliance "wins." Our expectation is to build on the current program using innovative best practices that will identify gaps in care faster resulting in even quicker identification and outreach. Ms. Shields, who is a licensed RN in Louisiana, has more than 15 years of nursing experience in the field of maternal child health. She holds a Master of Science degree in Nursing and a master's degree in Business Administration/Healthcare Administration. Ms. Shields has many years of experience in the State working closely with state partners and community partners to help further the goal of decreasing infant mortality and increasing birth outcomes.

Ms. Shields will continue to build on our current program to identify and coordinate assistance for members specific to maternal/child health and EPSDT and other preventive health strategies in compliance with RFP Section 4.2.13. Our program includes both administrative and direct services that place greater emphasis on disease prevention and earlier diagnosis and treatment of acute and chronic illness: *administrative services* include a variety of member/provider outreach

and follow-up activities; *direct services* offer comprehensive preventive health care screenings through contracted providers.

EPSDT Reporting

In compliance with RFP Section 6.6.5, we will report all EPSDT well-child services, blood lead screening, access to preventive services, and any other services as required for DHH to comply with federally mandated CMS 416 reporting requirements. We follow established policies, procedures and processes for identifying members who are due or overdue for EPSDT screening services. To be considered timely, all EPSDT screens, laboratory tests and immunizations take place within 30 days of their scheduled due dates for children under the age of two and within 60 days of their due dates for children age two and older.

EPSDT Provider Outreach

On a monthly basis, quality management staff members compile reports listing members and their families who are EPSDT-eligible. Our database allows us to generate reports based upon specific populations, households, or providers so that EPSDT services can be targeted for future office visits. Our clinical practice consultant (CPCs) team collaborates with providers to improve health outcomes for Bayou Health program membership, including improving HEDIS rates and will coordinate with Ms. Shields as appropriate.

EPSDT Non-Compliance

Ms. Shields will continue to be an integral part of our proactive, timely approach to ESPDT tracking, reporting and provider outreach. Reporting to medical management manager Linda Rintala, Ms. Shields is accountable for EPSDT program success and oversight on the monitoring of claims and encounter data on an ongoing basis to identify members who have failed to complete periodic screenings. Non-compliant members receive telephonic reminder calls and appointment/transportation assistance as needed. We will expand the process under this contract to include the option of a face-to-face visit, for selected cases, by a community health worker in the event that all standard outreach methods have failed to assist the member become compliant with their screenings.

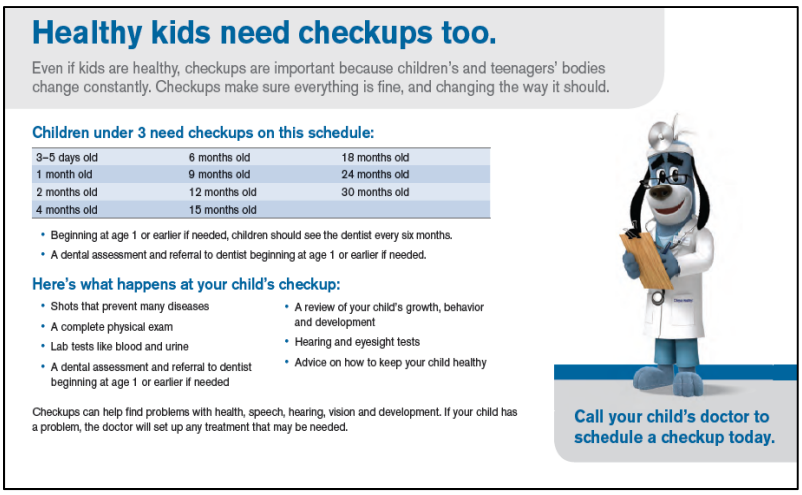
M.2 Describe your approach to member education and outreach regarding EPSDT including the use of the tracking system described in M.1 of this part and any innovative/non-traditional mechanisms. Include:

- How you will conduct member education and outreach regarding EPSDT including any innovative/non-traditional methods that go beyond the standard methods;
- How you will work with members to improve compliance with the periodicity schedule, including how you will motivate parents/members and what steps you will take to identify and reach out to members (or their parents) who have missed screening appointments (highlighting any innovative/non-traditional approaches); and
- How you will design and monitor your education and outreach program to ensure compliance with the RFP. (5 points)

In compliance with RFP Section 6.6., 12.2 and 12.11.4.3, we will continue to develop and distribute member educational materials to support ESPDT outreach, member appointment and preventive testing reminders. Materials will be member centric, culturally inclusive and accessible to non-English speaking members. Alternate communication mechanisms for EPSDT member outreach will be available (e.g., sign language, Braille, audio tapes) and interpretive services will be available through our member services team.

Approach to Proactive Member Education and Outreach

Recognizing that compliance often depends upon parental perception of the urgency and value or benefit of seeking preventive care for their children, we make every effort to educate members and their families and assist them in making and coordinating appointments. Building on methods already in place in Louisiana and leveraging those employed by us nationwide, we employ multiple communication strategies to enhance Bayou Health program member participation in the EPSDT program. Our proven communication tools include targeted mailers, reminder calls and direct person-to-person calls to proactively reach out to members regarding EPSDT screenings and services.



Healthy kids need checkups too.

Even if kids are healthy, checkups are important because children's and teenagers' bodies change constantly. Checkups make sure everything is fine, and changing the way it should.

Children under 3 need checkups on this schedule:

3–5 days old	6 months old	18 months old
1 month old	9 months old	24 months old
2 months old	12 months old	30 months old
4 months old	15 months old	

- Beginning at age 1 or earlier if needed, children should see the dentist every six months.
- A dental assessment and referral to dentist beginning at age 1 or earlier if needed.

Here's what happens at your child's checkup:

- Shots that prevent many diseases
- A complete physical exam
- Lab tests like blood and urine
- A dental assessment and referral to dentist beginning at age 1 or earlier if needed
- A review of your child's growth, behavior and development
- Hearing and eyesight tests
- Advice on how to keep your child healthy

Checkups can help find problems with health, speech, hearing, vision and development. If your child has a problem, the doctor will set up any treatment that may be needed.

Call your child's doctor to schedule a checkup today.

Figure 19. Member communication encouraging Healthy Kids checkups.

Our staff conducts creative outreach initiatives to reach EPSDT-eligible members, particularly those who are difficult to contact due to invalid phone numbers and addresses. Our staff also provides health education to parents or caregivers about the importance of their children receiving the requisite screenings and immunizations in a timely manner, as determined by the age-specific EPSDT periodicity schedule. The information we provide to members and their parents/guardians is always in an understandable language and at a comprehensible reading level. As necessary, interpreters facilitate communication between members and our staff or network health care providers.

Efforts to educate our members about the importance of EPSDT services begin at initial enrollment and continue throughout enrollment with UnitedHealthcare. We inform members about the EPSDT program via the *Member Handbook*, new member materials, quarterly *HealthTalk* and ongoing written or telephonic educational contacts. We develop member notification and reminder materials in compliance with literacy and cultural requirements. The content includes the benefits of preventive health services, a description of EPSDT services, recommended periodicity schedules, and information on how to obtain services.

EPSDT Innovation

We use a broad range of traditional (e.g., phone, mail, website) and innovative approaches (e.g., health fairs, community partnerships, school-based health clinics [SBHCs]) to close member gaps in care, for themselves and their families.

- ***March of Dimes "Healthy Baby Showers:"*** Through our local outreach activities, we sponsor the March of Dimes Community Healthy Baby Showers initiative in Louisiana, This program continues to provide necessary baby items and important education on prenatal care, nutrition and parenting, providing education and encouragement to expectant mothers, new moms and their support systems. Outreach activities such as this

provide us with additional opportunities to urge PCP selection for newborns and reinforce the need for regular preventive care.

- ***Text4Baby:*** We leverage our Text4Baby program, which sends out educational text messages to provide expectant mothers with information on child care and pregnancy to send reminder texts regarding PCP selection for newborns and follow-up well care.
- ***Twitter@UHCPregnantCare:*** The national Twitter handle @UHCPregnantCare targets our TANF audience who parallels Twitter's demographics. @UHCPregnantCare's messaging delivers health and wellness information relating to pregnancy, child birth and general health information applicable to pregnant women. We launched the first enterprise Spanish handle in January. @UHCEmbarazada (UHCPregnancy) has the same content as @UHCPregnantCare, but the Spanish handle gives our audience the option to choose their preferred language. All promotional materials are offered in Spanish as well.

Figure 20. Tweets You Can Trust help expectant and new mothers learn about their own health and how to keep their new babies healthy.

- ***Healthy First Steps:*** Healthy First Steps is our high-risk maternity case management program which provides personalized member interaction, focusing on improving birth outcomes and NICU avoidance through a multidisciplinary approach to care. We will leverage our Healthy First Steps maternity wellness program to telephonically educate mothers-to-be who are enrolled in the program about PCP selection for their baby and the need for regular preventive care.
- ***SBHC on Health Fairs:*** We have engaged successfully with Health Centers in Schools (HCS), the organization that supports health centers in East Baton Rouge Parish. We collaborated with HCS to conduct a health fair at ***Broadmoor High School*** in February 2014. Throughout the day, more than 350 students attended the fair during their physical education classes. Together with HCS, we promoted the importance of adolescent well child visits and screenings for sexually transmitted infections, including chlamydia. Other participants at the fair included

Figure 21. Broadmoor High Schoolers "Kinnect" with healthy eating and preventive health care information.

Pennington Research Center, institutions offering educational programs for careers in health care, and Trader Joe's who provided healthy snacks for the students. In April 2014, UnitedHealthcare was a sponsor for the annual Louisiana School-Based Health Alliance conference. In addition, the QMP director spoke on SBHC collaboration with the Bayou Health plans at the conference. Our chief executive officer April Golenor also spoke on SBHC collaboration with the Bayou Health plans at the 2013 Louisiana School-Based Health Alliance conference.

Traditional Member Outreach Strategies

Based upon our experience with Bayou Health program members, we continue to deploy a number of member outreach strategies in Louisiana tailored to the needs of members and their families.

- ***Newsletters:*** We present articles focused on preventive care and EPSDT required services to providers and members through provider and member newsletters.
- ***Member Website:*** Our member website (*myuhc.com*) is designed to meet the unique needs and challenges of our members by accommodating lower reading levels and multiple languages and offering culturally appropriate materials. The website offers helpful plan-specific links to a variety of services and information for members, including:
  - Searchable provider directory
  - Coverage status
  - Benefits search, including EPSDT
  - Downloadable *Member Handbook*
- ***Member Communication and the Member Handbook:*** We provide members with an expansive range of flyers, postcards, mailers and brochures to make members aware of their EPSDT preventive health benefits. Our *Member Handbook* is especially informative in providing an explanation of the services available to Medicaid members under age 21 through the EPSDT benefit, including periodic and as-needed health exams, vision, dental and hearing care, and all necessary diagnostic and treatment services to verify healthy growth and development. We provide an explanation to inform members that all EPSDT services are free and list a toll-free telephone number that members can call to receive assistance in scheduling an appointment and obtaining transportation. The *Member Handbook* also provides the following child health-related information:
  - An explanation of the Individuals with Disabilities Education Act (IDEA), a law ensuring services to children with disabilities throughout the nation. The IDEA program includes services aimed at early

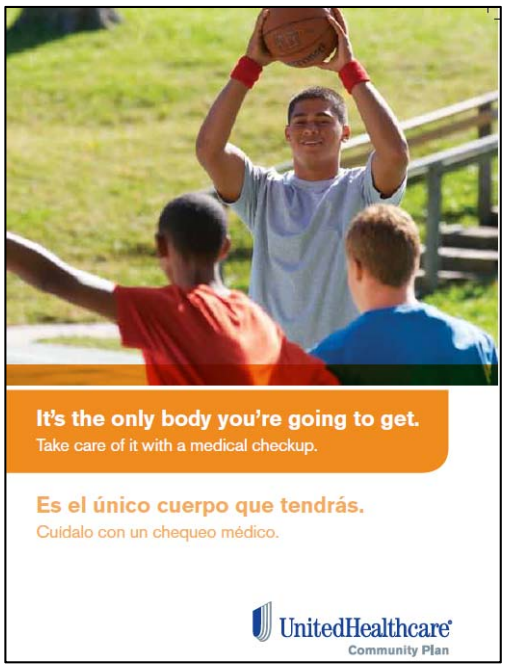


Figure 22. Adolescent Well Check-up Mailer in English and Spanish language.

intervention, preschool, and school-age children and adolescents, and instructions (including a telephone number) on how to request an IDEA evaluation for infants, toddlers or school-age children. Also included is information on growth and developmental benchmarks in young children and the signs of potential developmental delays.

- An explanation of immunization services for children and adults, immunization coverage as part of EPSDT, the importance of immunizations, the AAP recommended schedule for children and adolescents, and where and how to obtain immunization services
- An explanation of the health care needs of adolescents, including but not limited to special issues of growth and development, the impact of high-risk behaviors, and the role of EPSDT in ensuring receipt of appropriate health services to mitigate the health risks that emerge during adolescence

- ***Outbound Calls/Direct Person-to-Person Calls:*** Outreach calls are designed to encourage cooperation from parents of children (through age 20) who are due or overdue for EPSDT services. Using a variety of tools, including automated calls, personal calls or mailed reminders, we reach out to members prior to the due date of each EPSDT screening service. If a member cannot be reached telephonically, we send the parent a written reminder with a telephone number requesting a return call. If there is still no response, for selected cases one of our field-based outreach workers will make an in-person visit to urge the parent/caregiver to bring the child for his or her EPSDT appointment.
- ***Warm PCP Appointments:*** We partner with the member's PCP to ensure that we support the member in receiving needed care. We initiate "warm appointments" where we conference in the member and the provider to establish an appointment date and confirm that the member has the necessary transportation. We follow up with appointment reminder calls and postcards. As appropriate, we direct similar contacts to emancipated teenagers. This cycle continues throughout the year for members who are noncompliant with needed services.
- ***Bilingual Reminder Calls:*** We initiate automated reminder calls in English and Spanish. At any time during the automated call, a member can choose to talk to a member services representative if they want to switch to an in-person call. Members can also use the menu options to select language preferences. Bilingual staff members are available to handle direct member calls, and other language options are available through interpretive services.
- ***Care Manager Targeted Education and Reinforcement:*** During member interactions, care managers work with members and families/caregivers to provide culturally appropriate education and reinforce the importance of EPSDT visits and keeping appointments.
- ***Member Letter of Noncompliance:*** Our quality improvement department sends letters to the heads of households of any children who are noncompliant with EPSDT screenings. The letter encourages members or caregivers to contact us for assistance in scheduling an appointment with the child's PCP, to arrange transportation (as needed), or to address other barriers to accessing EPSDT services. We document all referrals and outreach, including face-to-face outreach with members who cannot be reached by phone or mail.

Working With Members to Improve Compliance with Periodicity Schedule

Recognizing that compliance often depends upon parental perception of the urgency and value or benefit of seeking preventive care for their children, we make every effort to educate members and their families and assist them in making and coordinating appointments. Building on methods already in place in Louisiana and leveraging those employed by us nationwide, we employ multiple communication strategies to enhance Bayou Health member participation in the EPSDT program. Our proven communication tools include targeted mailers, reminder calls and direct person-to-person calls to proactively reach out to members regarding EPSDT screenings and services.

Figure 23. Immunization flyer encouraging checkups and immunizations.

Innovative Outreach Methods

Under the direction of Ms. Shields and Ms. Rintala, we plan and conduct creative outreach initiatives to reach EPSDT-eligible members, particularly those who are difficult to contact due to invalid phone numbers and addresses. We provide health education to parents or caregivers about the importance of their children receiving the requisite screenings and immunizations in a timely manner, as determined by the age-specific EPSDT periodicity schedule. The information we provide to members and their parents/guardians is always in an understandable language and at a comprehensible reading level. As necessary, interpreters facilitate communication between members and our staff or network health care providers.

Our proprietary BayouCloud portal will identify and provide reporting on members who have missed scheduled services. Follow-up includes targeted outreach programs (e.g., telephonic, mail) by population and by provider to encourage these members to access services.

As described in this response (above) we use a broad range of traditional (e.g., phone, mail, website) and innovative approaches (e.g., health fairs, community partnerships, SBHCs) to close member gaps in care:

- March of Dimes "Healthy Baby Showers"
- Text4Baby
- Twitter@UHCPregnantCare
- Healthy First Steps
- SBHC on health fairs
- Newsletters
- Member Website
- Member communication and the *Member Handbook*
- "Warm PCP Appointments"
- Bilingual reminder calls
- Care manager targeted education and reinforcement
- Member letter of noncompliance

We collaborate with members and providers using the following process to improve EPSDT compliance:

- ***Automated reminder calls*** are made to members who are identified as non-compliant for EPSDT services and require a service in less than 90 days. On all automated calls, the member will have the opportunity to speak with a representative who will be able to

initiate a three-way call with a provider to schedule an appointment. They will also assist with transportation through LogistiCare.

- ***Live outbound calls*** are initiated to members who require the recommended services within the next 90 days. During live reminder calls, with member authorization, staff will attempt to initiate a three-way call with a provider to schedule the requisite appointment. Staff will also provide assistance with obtaining transportation if indicated.

Each member will appear in the list quarterly as long as the member remains non-compliant. If, at the time of member contact, the member indicates the service has already been received, the staff will obtain the name of the provider and approximate date of service(s) provided.

We make up to three attempts at different times of the day/evening to reach the member for automated and direct member calls. If the member cannot be reached telephonically, the Hospitality and Reminder Center (HARC) will send the member a postcard providing an inbound phone number for the member's return call. This cycle will continue throughout the year as long as the member remains noncompliant.

In addition to outreach calls, our quarterly member newsletter, *HealthTalk* provides information on recommended preventive health services including the recommended timing of such with the encouragement for members to obtain these services.

Motivating Adherence

In Louisiana, we have incorporated a variety of techniques to motivate and improve provider performance, quality of care and improve member adherence with well care visits as a result of our profiling efforts. These include:

- ***Clinical Practice Consultant (CPC) Visits***: Using RN CPCs to visit providers and share best practices and clinical tools that help providers identify areas for improvement.
- ***Provider Outreach:*** Conducting provider outreach with plan leadership and our provider network, member outreach and quality management departments to educate providers and review utilization patterns.
- ***Cobranded Member Outreach:*** Implementing a PCP-Cobranded Letter Program and high-touch member outreach and intervention program to encourage members to visit their PCP for needed screenings.
- ***Member Incentives:*** Establishing member incentive programs that encourage women and children to get care within HEDIS time frames.
- ***Maternity Incentives for Providers:*** Implementing provider incentive programs that give providers an incentive payment for completing certain tasks.

We use a broad range of traditional (e.g., phone, mail, website) and innovative approaches (e.g., health fairs, community partnerships, SBHCs) to close member gaps in care, for themselves and their families.

Designing and Monitoring Education and Outreach

Education and outreach are important initiatives to improve member compliance. Specific activities are determined based upon population needs, cultural competencies, and ability to impact behaviors thereby improving outcomes. Service utilization and results are regularly reviewed to determine areas for quality improvement. Our committee, consisting of our chief

medical officer Dr. Ann Kay Logarbo and Ms. Rintala, identify barriers and perform root cause analyses. Interventions deemed most appropriate to the targeted population are then designed or selected with the goal of affecting change.

Education can take a number of delivery formats such as a newsletter article, a flyer/brochure, booklet, provider request, case management discussion, and automated or live educational outreach calls. Our member service team routinely contacts members telephonically to educate members on the importance of screenings and encourages them to schedule visits with their physician. Members who are case managed for a chronic disease or pregnancy are also educated about self-management of their condition and offered assistance and encouragement to seek regular care with their PCP or medical home. To monitor the effectiveness of the education and outreach activities, the plan reviews process and outcomes data after the interventions have been implemented.

Clinical Practice Consultants: Confluence and Influence in LA
In 2013, Bayou Health program CPCs conducted HEDIS training at 281 PCP locations and distributed 409 Evidence-Based Quality Performance Guidelines toolkits developed by National Quality Management and Performance. Based upon the number of providers we impacted, we determined that we were able to influence the care of more than 131,900 members.

On a monthly basis, claims data from physicians is uploaded into a data warehouse for analysis and reporting. This claims data will be analyzed via the calculation of HEDIS well child annual visit rates, immunization rates, and other relevant EPSDT and HEDIS measures for this population.

Monthly Process Measure Analysis

We will determine the success of our intervention by establishing process metrics that will assess outcomes via process measures (e.g., number of members who were contacted as a proportion of members identified to be contacted) pre and post intervention. Processes or interventions will be adjusted based upon the results of the findings. Measurement and analysis of process measures will be performed monthly.

Monthly Outcomes Analysis

We will analyze the outcome measure rate(s) via monthly reporting updates for relevant measures provided to the quality director by comparing the rates to the initial measurement, the prior year's rate, the goal, and the benchmark for each relevant measure. Other state data may also be used in the analysis when appropriate. However, interim rates will be reviewed internally on a monthly basis, and analyzed quarterly. Outcome rates are also reported annually for all measures of quality care.

Statistical testing will be performed to determine if a statistically significant change has occurred from a previous/comparative time period. We will use statistical confidence rates and intervals and statistical significance. The percent of change and percentage point change for each measurement period is also noted.

As part of the data process to determine where to focus interventions, member level detail data (disparity analysis plan) will be analyzed, such as age, race, ethnicity, primary language and area (e.g., parish, ZIP code).

By monitoring the success of the education and outreach activities and drilling down data, we can identify the prevalence of noncompliance by the available factors. This analysis allows more focused interventions moving forward.

Section N: Utilization Management

N.1 Provided a detailed description of your utilization management (UM) policies and procedures including but not limited to:

- Specific levels of qualifications required for UM staff;
- Training you provide your UM staff;
- Industry products (Milliman, Interqual, etc.) used and how
- Describe any differences between your UM phone line and your member services line with respect to bullets (2) through (7) in item R.1 of this part;
- If your UM phone line will handle both Louisiana MCO and non-Louisiana MCO calls,
  - explain how you will track Louisiana MCO calls separately; and
  - how you will ensure that applicable DHH timeframes for prior authorization decisions are met. (10 points)

We agree to comply with each specification and requirement outlined in RFP Section 8.0 Utilization Management.

Since 2012, under the leadership of chief medical officer Dr. Ann Kay Logarbo, we have operated a multifaceted utilization management (UM) program that is well aligned with DHH's objectives and complies with requirements as outlined in RFP Section 8.0, including meeting all NCQA standards. Our Bayou Health UM program comprises a comprehensive, integrated, interdisciplinary set of principles, systematic processes, guidelines and criteria and defined accountabilities for monitoring and evaluating the quality, continuity, accessibility, timeliness and outcomes of physical and mental health and social/environmental services for our members in the state of Louisiana (State).

Our UM program supports a person-centered approach to integrated care and helps ensure Bayou Health members receive appropriate, effective, high-quality care, at the right time and in the most appropriate setting that meet the member's needs and the goals by:

- Promoting the management of health care services and facilitating access to care
- Developing data-driven population health management strategies to target super-utilizers
- Identifying and addressing gaps in medical and behavioral care and services, inclusive of social and environmental barriers to optimal health outcomes
- Identifying members' strengths and designing a plan of care that leverages their strengths and incorporates their preferences in the way health care services are delivered
- Providing resources to members to improve health status, including the use of community health workers to assist members with access to care issues
- Proactively identifying and referring individuals with chronic or complex physical or behavioral conditions into tailored programs that provide early interventions or alternative care options

Dr. Logarbo and the State's Medicaid medical director Dr. Rebekah Gee, routinely collaborate to tackle tough health care issues, such as improving care for members with sickle cell disease, providing covered benefits that provide life-saving treatment and working on benefit and payment reform to incent improved adherence to evidence-based clinical practice guidelines.

- Monitoring clinical coverage decisions for consistency with the member benefit plans
- Using provider advocates and RN clinical practice consultants to work with providers to review practice patterns of over and underutilization
- Coordinating program activities with customer quality improvement initiatives through collaborative programs across all components of care during an acute episode of illness

Utilization Management Program Objectives

Our UM program, in coordination with our quality management (QM) and clinical programs, provides mechanisms to review and evaluate the appropriateness of service requests for members, identifies member care opportunities and provides mechanisms to monitor our performance and identify improvement opportunities.

- ***Reviews service authorizations for a specific level of care*** to support the member's holistic needs and, when a member no long meets medical necessity criteria, make sure an appropriate new level of care is identified and assist the member during the transition.
- ***Supports our person-centered approach to integrated care*** by identifying care opportunities through analysis of clinical management system data, claims, prior authorizations, data from participating providers or delegated entities and state-supplied information, and coordinating services that meet the member's needs.
- ***Ensures the provision of high-quality member services*** by identifying areas for improvement and priorities, such as a reduction of admissions, inpatient bed days, readmissions and non-urgent ER visits, and supporting the efforts of our QM team to improve quality of care and service through programs, such as our provider program

Utilization Management Program Governance

Our key, local UM leadership team, comprises chief executive officer April Golenor, Dr. Logarbo, inpatient medical director Dr. Karl Ordoyne, our interim behavioral health medical director Dr. Charles Freed and medical management manager Linda Rintala, RN. Dr. Logarbo provides overall strategy and leadership direction for our clinical functions and activities and works in conjunction with Dr. Ordoyne, Dr. Freed, Ms. Rintala and performance/quality improvement coordinator Candace Young to implement and manage a UM program that meets all DHH requirements. In accordance with RFP Section 4.2.14, Ms. Rintala manages all required Medicaid management requirements under DHH policies, rules and the contract including:

> Our medical management manager, Linda Rintala, is a Louisiana-licensed RN. She has provided health care services to Louisianians for nearly 30 years and has nearly 10 years of Louisiana-specific experience managing UM operations.

- Ensuring adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria
- Ensuring that appropriate concurrent review and discharge planning of inpatient stays is conducted
- Developing, implementing and monitoring the provision of care coordination, disease management and case management functions
- Monitoring, analyzing and implementing appropriate interventions based upon utilization data, including identifying and correcting over or under utilization of services

- Monitoring prior authorization functions and assuring that decisions are made in a consistent manner based upon clinical criteria and meet timeliness standards

Utilization Management Committee Oversight

Our leadership team monitors our UM program through our Healthcare Quality and Utilization Management Committee (HQUM), a subcommittee of our Quality Management Committee (QMC). It meets quarterly, includes senior executives and decision makers and is chaired by Dr. Logarbo. Our HQUM complies with the requirements in RFP Section 8.2 and carries out specific functions and responsibilities, including:

- Overseeing and approving regular (at least annually) updates to UM and QM program descriptions, work plans, program evaluations, responsibilities, and policies and procedures that conform to industry standards
- Monitoring provider service authorization requests for health care services provided to members through provider quality and utilization profiling
- Monitoring the medical appropriateness and necessity of health care services provided to members
- Monitoring consistent application of medical necessity criteria and clinical practice guidelines
- Evaluating the consistency of UM decision making through review of inter-rater reliability reports and identifying over and underutilization issues
- Reviewing, editing and recommending adoption of updated clinical guidelines and utilization review policies and practices based upon input and recommendations from various sources, including our national clinical resources and local Provider Advisory Committee (PAC)
- Monitoring quality reports across all clinical areas; reviewing performance metrics, trends and outcomes related to care management; establishing data driven interventions to improve performance in identified areas; monitoring progress on clinical performance improvement programs; and conducting targeted quality and performance improvement studies
- Monitoring actions taken to investigate and ensure resolution of quality of care incidents, including UM issues
- Monitoring and correcting utilization variances, including over and underutilization of services
- Conducting and monitoring medical record review of member medical records to ensure providers deliver high-quality health care to members

Dr. Logarbo is a Louisiana-licensed pediatrician. Born in Louisiana, she has provided health care services to Louisianians for more than 30 years. Since 2012, she has served as our chief medical officer, continuously working with DHH, providers, medical facilities and the community to improve the quality of care and service provided to all Bayou Health members.

Utilization Management Integration with Care and Quality Management

Our integrated governance structure is specifically designed to meet the integrated physical and behavioral health needs of Bayou Health members. Key features of our integrated governance structure include:

- Integrated UM program description, QM program description and care management policies and procedures
- Common clinical (medical and behavioral health) platform, CareOne, to share member-specific information with other functional areas, including UM, service authorization, quality, appeals and grievances, and member services staff
- Use of common evidenced-based guidelines and criteria
- Interdisciplinary clinical management
- Common claims platform for a shared clinical view across disciplines (physical and behavioral)
- Integrated predictive modeling and clinical assessments with defined triggers for referrals to providers and Accountable Care Communities (ACCs)

Coordination with Quality Management

Our UM program is closely aligned with our QM program, providing targeted pre-authorization and concurrent and post utilization review activities to foster the provision of timely, cost-effective, evidence-based, medically necessary services. UM activities support our QM program by providing objective and systematic monitoring and evaluation of the necessity, appropriateness, efficiency, timeliness and cost-effectiveness of care and services provided to members. Inputs from our UM program provide critical evidence about health care patterns and practices and translate into effective policies and procedures for assuring high quality health care. Using UM data analysis, our QM and provider services teams work with providers to help them identify and close gaps in care and encourage them to refer members to needed services.

Additionally, our UM team collaborates with QM to meet accreditation standards through several means. Within the UM program there is a written description of the QM program, which is reviewed and updated by the QMC and approved annually. Our UM program sponsors quality committees, as necessary, to oversee certain services that support our program and function as subcommittees with accountability to our quality management committee, such as:

The State is investigating possibility of providing a skilled nursing facility (SNF) exception-based benefit instead of placing members in long-term acute care (LTAC) facility or inpatient rehabilitation. Based on the suggestion of Dr. Ordoyne, Dr. Logarbo presented the idea to create a SNF benefit in order to save on LTAC admissions to DHH in December 2013. This discussion has led to meetings with DHH and the nursing home foundation to develop the benefit. ***We estimate providing this benefit will save the State $800,000 annually.***

- Document vendor oversight committee that is responsible for policy, standard operating procedure and other document oversight and adherence
- Performance measurement documentation and communication committee that:
  - Identifies, tracks and trends staff performance
  - Communicates results of performance measurement results to the quality oversight committee and operations leadership
  - Implements improvement plans and documents actions taken to improve staff performance
- Delegated vendor oversight committee that provides oversight of UM delegation and business contracts

Coordination with our Clinical Team

We integrate UM activities with care management in a synchronized approach to meet the physical, behavioral and social needs of our members. UM activities are embedded into clinical processes and are part of effective prior authorization, inpatient management, discharge planning, service coordination and pharmacy management. These activities serve as a gateway to care coordination and case management activities by using authorization notifications to identify members with potential unmet health care needs who are likely to benefit from other interventions (e.g., referral to behavioral health services or disease management programs). Utilization management staff directly engages clinical staff whenever a member is presented for authorization of a new service, during the course of an episode of treatment (e.g., hospitalization) and through discharge plan development/transitions in care.

Medical directors, nursing staff and other professional support teams work closely with clinicians and providers to determine the medical necessity and appropriateness of care, avoid inappropriate use or duplication of services and to identify members who may require intensive care coordination upon discharge. Through Impact Pro, our predictive modeling software, we identify improvement care opportunities, ensure compliance with clinical care guidelines, and recommend health screenings customized for each member.

Service Authorization Policies, Procedures and Workflows

As presented in the figure below, our intake, prior authorization, concurrent review and discharge planning processes and workflows are supported by evidence-based nationally recognized medical policies, clinical guidelines and review criteria that influence care decisions to ensure members receive appropriate services, at the right time and in the right setting and that providers are appropriately reimbursed.

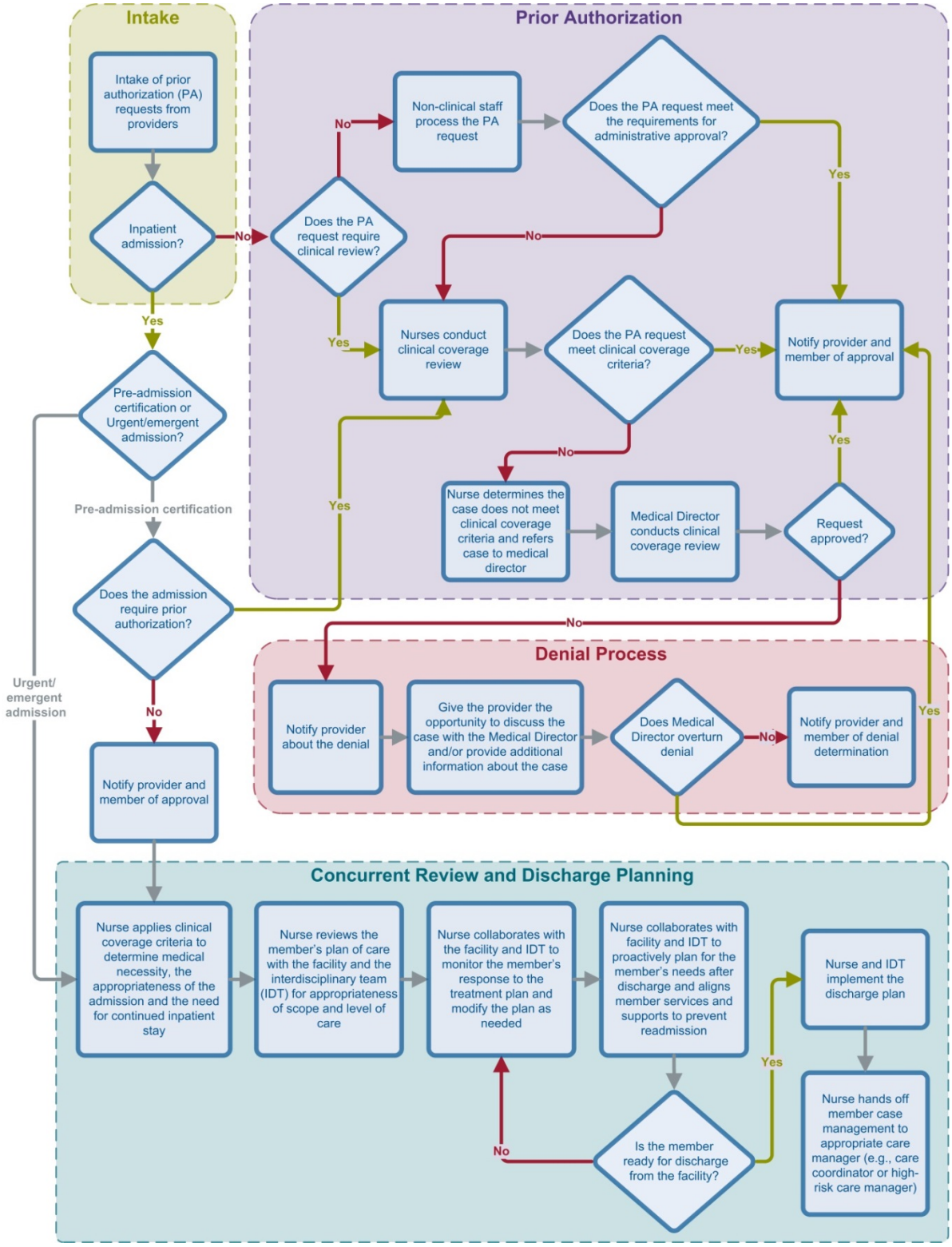


Figure 24. UM Processes. Our intake, prior authorization, concurrent review and discharge planning processes and workflows are supported by evidence-based nationally recognized medical policies, clinical guidelines and review criteria that influence care decisions to ensure members receive appropriate services, at the right time and in the right setting and that providers are appropriately reimbursed.

Service Authorization

Our service authorization processes (e.g., prior authorization, concurrent authorization and post authorization) meet the requirements in RFP Section 8.4. They include policies and procedures consistent with 42 CFR §438.210 and state laws and regulations for initial and continuing authorization of services and comply with the service authorization exception requirements in RFP Section 8.5.4.2. RFP Section

Our comprehensive health management system, CareOne, is the technology foundation for all of our care coordination and prior authorization processes in support of the Bayou Health program. It coordinates the information flow among caregivers, case managers, members and providers. CareOne maintains all of the information required for the member record, including all service authorization and utilization data, as required in RFP Section 8.1.21. CareOne is the authoritative source of service authorization data and provides an integrated, single solution for managing service authorizations for physical and behavioral health services.

We continue to make it easier for providers to do business with us through our BayouCloud dashboard, which allows providers to:

- Perform a quick check of whether or not prior authorization is required
- Submit electronic attachments of clinical records needed to support service requests
- Communicate electronically with our clinical staff
- Track the status of requests

Intake

The intake process supports varied administrative processes within UnitedHealthcare, including referral into case and disease management programs, advanced notification and admission notification and prior authorization. Intake involves obtaining member demographic information, physician/provider identifying information, planned services, hospital/facility identifying information and network status of providers and facilities. This information is used to build a case file related to the specific planned service and distribute individual cases to the appropriate operational unit within UnitedHealthcare. In certain instances, intake may administratively approve a service per our guidelines.

During intake, we receive prior authorization requests from providers or ACC practices and become aware of emergent inpatient admissions. Prior authorization requests must include the member's identification number; place of service; ordering provider; and current applicable CPT, ICD-10, DSM IV, CDT and HCPCS codes. Providers submit prior authorization requests for new or continuing medical and behavioral health services 24 hours a day, seven days a week via several methods, including telephone, fax or through our secure provider portal. Through the provider portal, BayouCloud, providers can, in addition to submission, verify approval, submit electronic referrals that require authorization and obtain real-time online verification of membership.

We provide 24 hours a day, seven days per week UM live phone staff coverage. Our intake department is available 24 hours a day, seven days per week to accept requests for prior authorization and providers can also send in requests through our secure provider portal 24 hours a day, seven days per week. Our intake department tasks these requests to our prior authorization team, which is staffed to adequately meet all timeliness requirements for both standard and expedited service authorization requests. NurseLine service is available to members 24 hours a day, 365 days a year and our UM phone staff can transfer a member to NurseLine if needed. In addition, emergency services do not require prior authorization at any time.

Prior Authorization

Our comprehensive health management system, CareOne, provides person-centered care coordination and is the technology foundation for all of our care coordination and prior authorization processes in support of the Bayou Health program. CareOne provides a 360 degree view of our members' care management information, such as utilization of services authorized, prescription history, health assessments and plans of care. It is the authoritative source of service authorization data and provides an **integrated, single solution** for managing prior authorizations for physical and behavioral health services.

Governing our prior authorization process is one set of policies and procedures for physical and behavioral services and common evidence-based guidelines. We use *MCG* (formerly *Milliman Care Guidelines*), *InterQual* criteria, Diagnostic and Statistical Manual (DSM) and Louisiana-specific guidelines, service definitions and level of care criteria specific to Bayou Health benefits and services.

Through Q1 2014 in Louisiana, we have received 11,554 prior authorization requests and approved 11,057. **We meet or exceed all State prior authorization timeliness requirements.** As of Q1 2014, we resolve:

- 95.2 percent of standard authorizations within two business days
- 99.8 percent of standard authorizations within 14 days
- 99.9 percent of standard authorizations with 28 days
- 99.4 percent of expedited authorizations within 72 hours

We make clinical coverage decisions that are consistent with the State's definition of medically necessary services and comply with all the contractually covered services, including the prevention, diagnosis and treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain or regain functional capacity. Clinical coverage decisions are based upon the eligibility of the member; State and federal mandates; the member's certificate of coverage, evidence of coverage or summary plan description; UnitedHealth Group medical policy; medical technology assessment information; and CMS National Coverage Decisions (NCDs) and Local Coverage Decisions (LCDs).

Medical directors, nursing staff and other professional support teams 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 to identify members who may need intensive care coordination upon discharge or may need to direction to their provider or ACC practice. We make all prior authorization decisions in compliance with the contract requirements in RFP Sections 8.5.1 (standard/routine authorization requests) and 8.5.2 (expedited authorization requests). To process prior authorization requests, UM clinicians:

- Review services to determine medical necessity and ensure the prior authorization request complies with level of care criteria and promotes alignment with clinical practice guidelines
- Notify the provider or ACC practice of the approval of the service request or refer the case to the appropriate medical director for review of any adverse benefit determinations
- Notify the provider or ACC practice of the service denial if we deny the request for services following peer review

Prior Authorization for Extended Nursing Services in the Home

We have implemented a private duty nursing (PDN) department dedicated to managing prior authorization requests for extended nursing services in the home or other specialized services for Bayou Health members. This department, staffed with PDN clinicians provides a consistent and efficient approach to managing complex members and ensures members benefit from an appropriate level of extended nursing services. Once our intake team receives the request, they route it to our PDN department, where clinicians review the case, verify that a letter of medical necessity and/or a physician order is present and request additional clinical documentation, if needed. Clinicians will use CareOne to review the case management notes, summarize the assessments and/or clinical documentation and forward the case to a clinical coverage review medical director for review. Our PDN department assesses for re-authorization of services at least every 60 days for skilled services and at least every six months for non-skilled services.

Concurrent Authorization and Discharge Planning

We do not require prior authorization for emergency admissions. For non-emergent admissions, UM clinicians determine if the admission requires prior authorization. If the clinicians determine the admission requires prior authorization, they process the admission through our prior authorization process for review and approval or denial. Once the member has been admitted, including urgent/emergent admissions, UM clinicians begin concurrent authorization and discharge planning. In accordance with RFP Section 8.5.1.2, we make concurrent review determinations within two business days of obtaining the appropriate medical information that may be required.

We conduct weekly rounds for high-risk case management and medical inpatient care management that include Dr. Logarbo, Dr. Ordoyne, Ms. Rintala, managers and all clinicians. This team reviews 10 to 15 UM cases and 6 to 8 case management cases each week. The team discusses complex cases and reviews the member's treatment plan. We also conduct weekly medical-behavioral rounds with Magellan to assure case management integration between medical and behavioral health services. These rounds will include our behavioral health medical director.

We recognize that poorly managed transitions of care often result in negative outcomes, including avoidable hospital readmissions. Discharge planning provides a proactive and well-coordinated plan for transitioning a member from an acute inpatient setting to the most appropriate setting focusing on quality, safety and member satisfaction. A key priority in our UM program is to begin discharge planning as early as possible after inpatient admission with updates through the concurrent review process.

Utilization management clinicians work with the facility, providers, member (and family/others as appropriate) to understand the member's covered benefits, other resources, plan of care, post discharge environment and needed services. Our network providers are encouraged to engage in the discharge planning process as early as feasible. We work as a team with the facility, providers, the member, the member's family to design and execute a successful transition of care, including discharge of the member to the least restrictive setting while ensuring quality and safety.

We have established protocols for discharge planning and post-discharge ambulatory follow up during initial and continued stay reviews. We route cases for clinical intervention based upon the diagnosis/procedure and on the ability to impact outcomes and decrease variation in care. We use an internally developed priority review list, based upon specific diagnostic categories, to identify

cases for inpatient case management and concurrent review. Inpatient cases are routed to nurses based upon our priority review list, which currently includes:

- Unplanned admissions
- Readmissions within 30 days
- Non-priority cases that have reached the length-of-stay (LOS) threshold
- Sub-set of planned surgeries with known complex discharge planning needs or historic practice variation:
  - Total hip replacement
  - Open reduction, internal fixation (ORIF) for hip or femur
  - Total knee replacement
  - Large and small bowel procedures

Dr. Logarbo was approached by a Tulane hematologist about performing genetic testing for familial hemophilia. She collaborated with Dr. Gee to add the testing to the fee schedule.

Inpatient management is not limited to patients undergoing these surgical procedures and our priority review list is likely to change periodically depending on utilization trends and other factors. For specified diagnosis, and cases where the length of inpatient stay falls within the targeted evidence-based goals, the case may not be initially referred to a nurse for review. In these instances, the admission and discharge dates will be confirmed. If needed, the case will be referred to a nurse when the length of stay exceeds the targeted or expected length of stay.

Post Authorization

We conduct retrospective reviews in accordance with RFP Section 8.5.3 to determine the medical necessity of treatment or services already delivered. We make retrospective review determinations within 30 days of obtaining the results of any appropriate medical information that may be required, but no later than 180 days from the date of service. We follow the same process for conducting retrospective reviews as for prior authorization. In addition, we take into consideration unique member and provider circumstances, including transition of care needs. Services provided in acute care facilities, rehabilitation and skilled nursing facilities are subject to potential retrospective review to verify that the member received timely and appropriate care and treatment. Retrospective reviews are conducted by Louisiana-licensed clinical professionals under the direction of Dr. Logarbo.

Denying a Service Authorization Request

Our policies and procedures for denying a service authorization request are compliant with RFP Sections 6.1.6, 8.1.6.4 and 8.1.16 through 8.1.19. We follow this process when denying a service authorization:

- The UM clinician sends cases requiring further review for determination to the appropriate medical director.
- Medical directors perform peer-to-peer counseling to make a determination and review requests that do not meet our coverage criteria, including medical necessity. The medical director consults with the requesting provider or ACC practice.
- When an adverse determination has been made, the UM clinician communicates the service denial to the provider or ACC.

- We send a Notice of Action letter to the member and the requesting provider within the required timelines and format and with a clear explanation and basis for the adverse determination.

Each Notice of Action includes at a minimum of the following:

- The action taken or intended to be taken
- The reason for the action
- The member's right to file an appeal with UnitedHealthcare
- The procedures for exercising appeal rights
- Circumstances when expedited resolution is available and how to request it
- Procedures for continued benefits and the member's potential financial obligation for them.

We also include all appropriate parties to the appeal, including the member, legal representative, or legal representative of a deceased member's estate.

Ensuring Members Receive Life-Saving Care

In early May 2013, our prior authorization team received a request for genetic testing of an 8 year old Bayou Health member with a family history of arrhythmia. Specifically, the pediatric cardiologist, Dr. Jackson, affiliated with LSU Shreveport, was asking for genetic testing for prolonged QT syndrome. The testing was not a covered benefit with Louisiana Medicaid. Prolonged QT syndrome is difficult to diagnosis clinically, frequently overlooked, and typically diagnosed post mortem as the cause of death prior to the availability of this genetic test.

Dr. Logarbo collaborated with Dr. Gee, to discuss the importance of diagnosis in asymptomatic children who can be treated and prevented from sudden cardiac death. After considering the potential benefits, Louisiana Medicaid agreed to add the testing as a covered benefit if certain conditions, such as family history, were met.

The member tested positive for the gene and had an internal defibrillator placed to prevent sudden fatal tachycardia.

Informal Reconsideration Process

Our informal reconsideration process, which is compliant with RFP Section 8.5.4.1.3, facilitates resolution of requests and reduces the number of overall formal appeals. Our goal is to resolve issues as expeditiously as possible before they result in an appeal or delay a member's care. If we receive insufficient clinical or other information for a covered service to be authorized or the available information does not meet the medical necessity criteria for the covered service to be authorized during our normal prior authorization review process, UM staff make two attempts to obtain this information from the ordering physician.

If the ordering physician does not supply the necessary information resulting in an adverse determination, UM staff offers a peer-to-peer (P2P) discussion with a medical director within one day of the request to facilitate resolution of any member requests to reconsider the denial or limited authorization of requested services before an appeal is initiated.

Medical directors who conduct peer clinical review are qualified health professionals, with current license to practice medicine, or current license in the same category as the

treating/ordering provider. Only peer clinical reviewers render adverse determinations for clinical review outcomes. In the case of clinical adverse determination, the peer clinical reviewer or their alternate are available within one business day to discuss determinations with requesting providers.

If, after all new information is reviewed, the covered service still does not meet medical necessity criteria, our medical management staff will request all available and necessary information relevant to the pre-appeal, by contacting the member or the provider acting on behalf of the member.

Generally, we make all decisions within 14 days of receipt of the original request and understand that the informal reconsideration process will not extend the 30-day required timeframe for a Notice of Appeal Resolution.

Specific Levels/Qualifications Required for Utilization Management Staff

The UM department functions as an inter-disciplinary team that places the member in the center of all activities. All UM decisions are based upon appropriateness of care and service and the existence of coverage. UM decision makers are not rewarded for issuing denials of coverage or care nor do they receive financial incentives that encourage decisions that result in underutilization. Members of the team include the following staff:

- Chief medical officer Dr. Ann Kay Logarbo (oversees the UM program and determines medical necessity)
- Inpatient medical director Dr. Karl Ordoyne and other medical directors (determine medical necessity)
- Behavioral health interim medical director Dr. Charles Freed (determines medical necessity)
- Medical management manager Linda Rintala (manages the UM program and reviews medical necessity)
- Inpatient care management director (manages concurrent review and discharge planning)
- Utilization management nurses (perform intake and prior authorization)
- Non-clinical support staff (supports the efforts of the UM team)

Chief Medical Officer

Dr. Logarbo works closely with staff, interfaces with the delivery system and coordinates interventions and exchange of clinical information between UnitedHealthcare and the provider network. Dr. Logarbo:

- Provides clinical consultation
- Provides oversight for clinical activities
- Develops and implements the medical and behavioral health clinical components of the UM program
- Develops clinical strategies to improve UM policies, procedures, processes and outcomes
- Oversees clinical decision-making activities of UM staff; only a Louisiana-licensed physician can deny services
- Conducts peer-to-peer clinical reviews
- Determines medical necessity

- Approves all adverse benefit determinations and oversees the Louisiana clinical appeals process/decision making
- Ensures reasonable availability, within one business day, to discuss clinical determinations with the attending or ordering physician
- Obtains consultations from specialist physicians if indicated
- Oversees clinical appeals process/decision making
- Facilitates grand rounds and case conferences
- Develops, implements and interprets medical policies and procedures including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, and medical review included in the MCO Grievance System
- Administers all medical management activities of the MCO
- Serves as member of and participates in every quarterly and phone meeting of the Medicaid Quality Committee either in person or by phone; may designate a representative with a working understanding of the clinical and quality issues impacting Medicaid
- Serves as the director of the HQUM and chairman or co-chairman of the Quality Assessment and Performance Improvement (QAPI) committee

Qualifications include:

- Maintain a current non-restricted license to practice medicine in Louisiana
- Demonstrate adequate education, training and clinical experience in a medical or clinical practice setting to use medical appropriateness criteria and other applicable review standards or medical policy
- Maintain ability and credentials (for example, Board Certification) to review cases for which a clinical decision cannot be made by the first level reviewed
- Achieve and maintain credentialed status with UnitedHealthcare
- Has at least three years of training in a medical specialty and five years' experience post-training providing clinical services
- Has achieved board certification in their specialty

Medical Directors

Dr. Ordoyne and more than 250 national UnitedHealthcare medical directors, licensed in more than 40 specialties, make medical necessity determinations in Louisiana. Medical directors:

- Determine medical necessity
- Develop and implement clinical (medical or behavioral health) components of UM program
- Develop clinical strategies to improve UM policies, procedures, processes and outcomes
- Ensure reasonable availability, within one business day, to discuss clinical determinations with the attending or ordering physician
- Obtain consultations from specialist physicians if indicated
- Develop clinical policies, procedures and programs

- Oversee clinical appeals process/decision making

Qualifications include:

- Maintain a current non-restricted license to practice medicine in Louisiana
- Demonstrate adequate education, training and clinical experience in a medical or clinical practice setting to use medical appropriateness criteria and other applicable review standards or medical policy
- Have the ability and credentials (for example, Board Certification) to review cases for which a clinical decision cannot be made by the first level reviewer

Behavioral Health Medical Director

Dr. Freed works directly with Dr. Logarbo, clinical staff and providers to promote comprehensive care and coordinated interventions. Dr. Freed is responsible for the oversight of the behavioral health clinical activities and physician consultations. Dr. Freed also ensures that care advocacy activities are clinically sound, including clinical supervision, training and consultation with our behavioral health care advocates and oversees coverage determinations and appeal reviews. Dr. Freed will be an integral part of interdisciplinary rounds and joint rounds with the behavioral health state management organization (SMO). Responsibilities include:

- Oversee, monitor and assist with the management of psychopharmacology pharmacy benefit manager (PBM) activities, including the establishment of prior authorization clinical appropriateness of use, and step therapy requirements for the use of stimulants and antipsychotics for all enrolled members under age 18
- Provide clinical case management consultations and clinical guidance for contracted PCPs treating behavioral health-related concerns not requiring referral to behavioral health specialists
- Develop comprehensive care programs for the management of youth and adult behavioral health concerns typically treated by PCPs, such as attention deficit hyperactivity disorder (ADHD) and depression
- Develop targeted education and training for Bayou Health PCPs related to commonly encountered behavioral health issues frequently treated by PCPs

Qualifications include:

- Hold a current, unencumbered license through a State Board of Medical Examiners
- Is a board-certified psychiatrist in the state of Louisiana
- Has at least five years of combined experience in mental health and substance abuse services

Medical Management Manager

Ms. Rintala maintains accountability for the overall (clinical programs) care coordination, UM and disease management program planning and execution at the site level. Ms. Rintala:

- Develops relationships with internal and external customers to ensure clinical operational processes support program goals and state contractual requirements
- Sets overall strategic direction and plans for clinical services delivered by the health plan

- Ensures oversight and accountability of clinical staff to deliver contract requirements and high quality services
- Ensures clinical reporting is in place to monitor and track clinical operational and member transition metrics
- Works collaboratively with site medical director and inpatient care management (ICM) director to ensure seamless member care coordination and transitions
- Works with medical director and executive director to develop and execute medical expense management plans
- Serves as a liaison to and with state partners
- Maintains internal and external reporting requirements

Qualifications include:

- Maintains license in the state of Louisiana as a RN

Inpatient Care Management Director

Under the direction of Ms. Rintala, the inpatient care management director maintains accountability for the ICM team and maintains accountability for the team achieving the established ICM team program goals. The inpatient care management director:

- Monitors compliance with regulatory standards for timeliness and documentation
- Ensures oversight and accountability of clinical staff to deliver contract requirements
- Ensures clinical reporting in place to monitor and track operational and member utilization metrics
- Promotes a positive public image, facilitates the establishment of effective and efficient internal and external customer interfaces, and ensures development of staff through the implementation of logically developed goals, objectives and strategic plans.
- Achieves and maintains budgets as impacted by medical expenses and trends in each of the regional sites
- Sets directions and strategic planning to develop, implement and monitor action plans to modify care delivery patterns and reduce expenses
- Reduces medical expenses that correlate with continuous performance improvement efforts
- Develops strategic initiatives as ongoing improvement
- Produces analysis documents to guide strategic planning
- Works collaboratively with local plan medical and health services directors to ensure plan goals and contractual requirements for acute UM are met

Qualifications include:

- Maintains license in the state of Louisiana as a RN

Utilization Management Nurse Responsibilities

Under the direction of Ms. Rintala, our Louisiana-licensed UM nurses perform UM and determine the medical appropriateness of outpatient services following medical guidelines and benefit determination guidelines. They:

- Collaborate with medical directors to render decisions in a timely manner
- Identify solutions to non-standard requests and problems
- Review all case-pertinent medical records, consultant reports, progress notes, laboratory and X-ray reports, and other relevant information, taking into account characteristics of the local delivery system available for members and any member-specific factors
- Consult with the requesting provider to clarify the medical necessity of a request
- Apply criteria to clinical information presented for intensity of service, appropriateness of setting and coverage
- Use established criteria for home and community-based service (HCBS) authorization, evaluate the appropriateness of proposed services and certify cases meeting criteria
- Approve cases meeting criteria
- Refer cases not meeting criteria to a physician reviewer for review and adverse determination
- Provide the link between the UnitedHealthcare, the member and the PCP
- Focus on early discharge planning
- Work closely with hospital discharge planners to determine most appropriate discharge setting
- Initiate referrals to discharge case managers and transition case managers based upon member needs and risk for readmission.
- Review for medical necessity and appropriateness for home health, skilled nursing facility, infusion therapy and rehabilitative services
- Determine member eligibility for all provider service notifications and prior authorization requests and log the requests into CareOne
- Match prior authorization requests with current prior authorization approved list
- Approve requests within the limits of the defined prior authorization list and notifies providers and members
- Direct requests outside the plan prior authorization limits to medical director for medical necessity review and determination
- Send denied requests through appropriate notification process

Qualifications include:

- Maintains license in the state of Louisiana as a RN

Non-Clinical Support Staff

Non-clinical support staff supports the efforts of our UM team and improve service to members and providers by performing non-clinical tasks:

- Manage incoming calls and requests for services from providers and members
- Provide information on available network services and transferring members as appropriate to clinical staff
- Manage the referral process by processing incoming and outgoing referrals and prior authorizations, which include intake, notification and census roles
- Handle intake, verify member eligibility and entry of approved services into CareOne

- Review member requests for durable medical equipment (DME) and supplies to determine if within plan defined limits
- Escalate member service requests that have not been approved by the case manager to manager of case management for action
- Notify provider and member when services are approved and enter the services into CareOne
- Triage case management calls and escalate to the manager of case management to ensure timely responses and follow up
- Escalating any member grievances to the plan's grievance and appeals contacts

Training Provided to Utilization Management Staff

Every member of our staff undergoes intensive UM and Louisiana-specific training. This includes, but is not limited to, the usual and customary new employee orientation as well as ongoing mandatory training including job specific updates, policy change processes/workflow and the maintenance of job specific performance standards. UM staff has access to and instructions on how to access GPS and mapping search engines for the purposes of authorizing services, recommending providers and transporting members to the most geographically appropriate location.

In new hire training and annually thereafter, UM nurses are educated on the global aspects of health services. This includes, but is not limited to, a summary of the quality management program, critical thinking, compliance with HIPAA, fraud and abuse, the concepts of medical necessity and various condition-specific programs. During this time, the UM staff is exposed to the referral process and specific contacts. They are introduced to the community outreach and behavioral health teams. We expose them to their role in the managed care setting, while educating them about the application of the medical necessity guidelines. We integrate Louisiana-specific policies into the appropriate course content area.

A critical aspect of the UM process is the consistent application of the medical necessity guidelines. To ensure the same utilization review standards are maintained by each individual reviewer and promote consistency surrounding the decision-making processes, it is the policy of UnitedHealthcare that all clinical staff makes medical necessity decisions based upon national evidence-based guidelines. We test this consistency by performing inter-rater reliability (IRR) testing on all UM nurses. The IRR testing process is based upon systematic review that determines congruence in outcomes among clinical peer reviewers and other health care professionals. Included in this process is the evaluation of evidence-based guideline criteria application, guideline navigation, understanding of workplace policies and procedures, and knowledge of regulatory agencies requiring compliance and timeliness guidelines.

We conducted clinical staff *MCG* inter-rater reliability (IRR) assessments in Q3 2013 to establish the consistency of training and guideline application among clinical reviewers, both physician and non-physician. The IRR assessment process consists of four distinct steps for each of the *MCG* products: inpatient care, ambulatory care and recovery facility care. The results of our assessment included:

- Inpatient care: 1,354 participants – 98 percent passed
- Ambulatory care: 730 participants – 99 percent passed
- Recovery facility care: 639 participants – 97 percent passed

The IRR process begins with quarterly, instructor-led sessions that provide a standardize approach to assessing cases, clinical information obtained, diagnoses and evidence-based guidelines when clinical staff make determinations. The instructor-led sessions are conducted quarterly during the mandatory IRR Grand Rounds. The Grand Rounds has a facilitator noted by UnitedHealthcare to be a subject matter expert in the fields of *MCG* and *InterQual*, critical thinking and utilization review.

The Grand Rounds facilitator ensures that standardized approaches to case scenarios are followed and proper critical thinking skills and evidence-based guidelines are used when clinical staff encounters a case which requires a medical determination. Additionally, on an annual basis, IRR case scenario testing is administered for all clinical staff through LearnSource, our learning management system. Automatic email communications are generated directing staff that the course is assigned in their development plan in LearnSource.

Annual IRR testing is mandatory for all clinical staff. We conduct three IRR testing modules focusing on the following *MCG* products: Inpatient and Surgical Care Guidelines, Ambulatory Care Guidelines, and Recovery Facility Guidelines are trained and tested. We have a defined remediation process for those who failed or were enrolled but did not complete the testing. The training team follows up with these individuals and their managers, and arranges retraining courses and retesting. We provide summary data to our senior leadership and internal oversight committees.

Clinical staff is expected to achieve a score of at least 90 percent. If 90 percent score is not achieved, training and retesting will be done. Clinical staff is able to retake the IRR test up to three times, with retraining needs addressed in between each test that was failed. If a staff member does not pass after the third IRR test, then a 30-day corrective action plan will be derived by the hiring manager to correct any deficiency. After the-30 day corrective action period is completed, the employee takes the IRR for the last and final time. If the employee does not pass, the hiring manager must determine if the employee is suitable to remain as part of the clinical staff.

The IRR is typically connected with the employee's Maximizing Accountability and Performance goals and objectives for the year, which helps ensure that employees are responsible for being proactive in their success within the company and share the accountability to patient care. Completion reports are run to determine scores and staff that have completed the IRRs. Results are reported to the integrated care coordination team (ICCT) leadership. ICCT leadership provides feedback to the team at large and to individual team members when the scores become available. The IRR score results are also forwarded to the national training consultants to make them aware of future training needs. The audit results are also presented to the appropriate Louisiana health plan leadership and the National Quality Management Oversight Committee (NQMOC) on at least an annual basis.

Industry Products Used and How

We use evidence-based, nationally recognized *MCG* and *InterQual* criteria in our medical management program to assist us in administering health benefits and to assist clinicians in making informed decisions in many health care settings. These tools are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

We analyze externally developed physical health guidelines (either written by a professional specialty society or national government organization) and adopt them through our National Medical Care Management Committee (NMCMC) and national Medical Technology Assessment Committee (MTAC).

Our NMCMC develops, implements and evaluates UnitedHealth Group's national UM program. Our UM program in Louisiana is based upon the national UM program. The NMCMC comprises physical and behavioral health medical directors and strategic leadership and meets quarterly to develop, review, evaluate and approve clinical protocols, policies and procedures. It evaluates new and emerging technologies; reviews and approves preventive health guidelines and written clinical policies; and evaluates, revises and approves commercially developed medical guidelines. The NMCMC updates preventive service guidelines, medical policies and clinical practice guidelines at least quarterly and communicates revisions to our UM clinicians via bulletins, training classes and online.

Our MTAC, comprising medical directors, clinicians and network physicians, develops, reviews and approves criteria, guidelines and new medical policies. It meets at least 10 times annually to develop new policies in response to emerging technology or new treatments based upon scientific evidence, where such evidence exists. MTAC's approved criteria and guidelines are presented to the NMCMC for approval. MTAC:

- Develops and reviews evidence-based position statements on selected medical technologies
- Reviews and provides maintenance of externally licensed guidelines
- Reviews guidelines developed by and for the use of UnitedHealth Group
- Monitors consistent clinical decisions regarding the safety and efficacy of medical care across all programs and businesses
- Manages medical policy development and adoption, including the adoption of Utilization Review Guidelines (URGs)
- Assesses the evidence supporting new and emerging technologies and new indications for existing technologies

In December 2013, our chief operating officer Karl Lirette presented DHH with an analysis of costly drugs, such as the new Hepatitis C drug, Sovaldi. Our analysis showed that 14 percent of expenses came from one percent of utilization. Dr. Logarbo and Mr. Lirette recommended adding clinical guidelines to include these drugs in the State formulary, with prior authorization. On May 12, 2014, the Louisiana Drug Utilization Review Board adopted these guidelines.

Once approved by the NMCMC, all physical and mental health criteria and guidelines are forwarded to our Louisiana HQUM, QMC and PAC for review, acceptance and adoption for Bayou Health members. Dr. Logarbo coordinates this review to ensure our criteria and guidelines are appropriately tailored for Bayou Health members. We communicate new policies and policy revisions to our staff, network physicians and other health care providers through ongoing training, monthly Medical Policy Updates bulletins, our Internet and intranet sites, and continuing education programs.

We will also solicit input into the development of medical policies via our secure provider portal, BayouCloud. All UnitedHealthcare coverage determination guidelines (CDG) and medical

policies are available to contracted providers on BayouCloud. We encourage network providers to review our medical policies and provide feedback to us.

Disseminating Practice Guidelines to Providers and Members

We foster clinician adherence to clinical practice guidelines by giving providers convenient access to practice guidelines via our secure provider portal, BayouCloud, or paper copy upon request. We inform providers of the availability of the guidelines in *Practice Matters*, the provider newsletter and the *Provider Administrative Guide*. We provide practice guidelines to members on our secure member website, *myuhc.com*, in our quarterly member newsletter, *HealthTalk*, and to potential members on our public website, *uhccommunityplan.com*. All adverse determination letters state that the clinical review criteria upon which the non-certification determination was made are available upon request by the member or provider. This information is provided in writing when requested.

Differences between Utilization Management and Member Services Lines

Generally, the most significant differences between our UM phone line and member services line are the types of callers to each line (e.g., members calling our member services line and providers calling our UM line) and the types of services provided by each line (e.g., member support from our member service line and service authorizations from our UM line). Both lines use similar technologies to route calls and have access to similar information through CareOne. We present the capabilities of our member services line in Section R.1 and the differences between our member services line and UM line in the following sections.

Routing Calls to Appropriate Persons and the Information that is Available

Our UM phone line processes calls in a manner similar to that of our member services line. Our UM phone line is area code routed and auto-routed to staff assigned to answer calls for specific plans. It has a transfer destination list that houses commonly used phone numbers to quickly transfer any calls as needed. Upon receiving a call, our intake team processes the call, gathers required information and administratively approves a service request per our guidelines or routes the call to our clinical team for medically necessity determination. The intake team can also refer calls to our care coordination and disease management programs. Because we use CareOne as the foundation of our care coordination and prior authorization processes, our member services and UM staffs have access to similar information about members, the services they use and the services that have been authorized.

Members with Limited English Proficiency and Who are Hearing Impaired

Our UM line handles calls from members (or providers) with limited English proficiency and persons who are hearing impaired in the same manner as our member services line. Through Language Line, our intake team can provide callers with access to more than 170 languages to meet their communication needs. We use the 711 National Telecommunications Relay Service (TRS) TTY line to facilitate communication with hearing impaired members, and print the telephone contact information on all member mailings and marketing materials. Our UM intake team is trained on handling calls from TRS operators who are assisting our hearing impaired members.

Monitoring Process for Ensuring the Quality and Accuracy of Information

We monitor the quality of calls to our UM phone line in a manner similar to that of our members services line. However, instead of silent monitoring of live calls, our UM phone line uses Qfiniti

software to audit individual performance. Qfiniti records and captures individual audio and data entry information for later review by an auditor, who reviews and evaluates calls for accuracy and professionalism.

Monitoring Process for Ensuring Adherence to Performance Standards

Our UM line processes and tools are similar to those employed by our member services line to ensure adherence to performance standards. In addition, we perform workforce management and forecasting by continuously monitoring our UM phone line to monitor real-time staff schedule adherence and adherence to performance metrics. Our management team monitors the performance of our UM phone line through daily UM phone system reports that track abandonment rate, average speed of answer, calls offered and calls handled tracking information.

Interacting with other Customer Service Lines Maintained by State, Parish or City Organizations

Similar to our member services line, our UM line supports interactions with other customer service lines, such as those maintained by the State, parish or city organizations, by performing a warm transfer to our member services line or to our care management team to assist the member with the call as described in Section R.1.

After Hours Procedures

Similar to our member services line, our UM line provides 24 hours a day, seven days per week phone coverage. Our intake department is available 24 hours a day, seven days per week to accept requests for prior authorization and providers can also send in requests through our secure provider portal 24 hours a day, seven days per week. Our intake department tasks these requests to our prior authorization team, which is staffed to adequately meet all timeliness requirements for both standard and expedited service authorization requests. Similar to our member services line, NurseLine service is available to members 24 hours a day, 365 days a year and our UM phone staff can transfer a member to NurseLine if needed.

Utilization Management: Handling Louisiana and Non-Louisiana Calls

Our centralized UM point-of-access system handles calls regarding both Louisiana Bayou Health members and non-Louisiana MCO members.

Tracking Louisiana Calls Separately

Our membership calls are routed based upon the area code of the caller so the UM phone staff immediately have the correct information for the location of the provider or member making the call. The UM information system provides staff with real time access to any member's eligibility and benefit information, and records all interactions that occur through the UM intake process. On an ongoing basis, UM reports monitor the number and type of calls by contract.

Meeting DHH Prior Authorization Decision Timeframes

Utilization management clinicians are required to comply with DHH's prior authorization timeframe requirements or the more stringent/restrictive requirements of applicable NCQA or federal requirements when conducting reviews. Applicable DHH prior authorization timeframes include:

- Making all prior authorization decisions in compliance with Sections 8.5.1 (standard/routine authorization requests and concurrent review determinations) and 8.5.2 (expedited authorization requests).

- Making post authorization (retrospective review) determinations in accordance with Section 8.5.3.
- Providing notices of action (approval and adverse) in accordance with Section 8.5.4.1.
- Conducting informal reconsiderations in accordance with Section 8.5.4.1.3.

We have continually enhanced the capabilities of our provider portal to improve service to providers and ensure adherence to DHH timeframes. Enhancements since program inception include:

- Obtaining online notification/prior authorization for services requiring prior authorization
- Displaying completed authorizations
- Access to remittance advice
- Verifying member benefits and eligibility
- Obtaining claims status
- Submitting online claim review requests

Using a combination of technology, training, processes and system monitoring, we ensure that our prior authorization decisions meet DHH timeframes.

Technology. CareOne is the technology foundation for our prior authorization processes in support of the Bayou Health program. It is the authoritative source of service authorization and utilization data and provides an integrated, single solution for managing service authorizations for physical and behavioral health services. Our UM clinicians use CareOne to provide integrated prior authorization management and UM. CareOne helps ensure that UM clinicians make prior authorization decisions in compliance with DHH timeframes by tracking service authorization timeframes.

Training. We train clinical reviewers on the consistent application of medical necessity guidelines and Louisiana's specific timeliness requirements and plan benefits.

Processes. We triage service authorization requests to assure all requests for prior authorization are resolved in accordance with DHH timeframes. For example, our intake team determines if a request is for standard or expedited prior authorization. If the request is for expedited prior authorization, we determine if the request meets the criteria for expedited processing. If so, our expedited task group processes the expedited request, in accordance with DHH expedited prior authorization requirements, using our Intake of Expedited UM Requests Standard of Practice (SOP). If the expedited request does not meet the criteria for expedited processing, we process the request using our standard prior authorization processing timeframes.

Our intake department is available 24 hours a day, seven days per week to take in requests for prior authorization and providers can also send in requests through our secure provider portal 24 hours a day, seven days per week. Our intake department tasks these requests to our prior authorization team, which is staffed to meet all timeliness requirements for both standard and expedited service authorization requests. Our prior authorization team makes decisions 24 hours a day, seven days per week.

Non-clinical staff process requests that do not require clinical review, such as confirmation of member eligibility, confirmation that the provider is in network and confirmation of the member's benefit coverage. We do not require prior authorization for emergency inpatient admissions. For non-emergent inpatient admissions, a UM clinician determines if the admission requires prior authorization and, if so, processes the admission through our prior authorization process.

Monitoring. Our QM department continuously monitors our service authorization processes and adherence to processing timeframes through QM program file and letter audits. We pull a 95 percent confidence level sample for monthly review of compliance to internal policy, State and federal regulations, and outside accreditation agency standards to document baseline performance and incremental performance. When we identify deficiencies, our QM department collaborates with our clinical regulatory audit team and operations team to identify root causes and develop improvement plans, such as increased or revised training, process improvements or additional support tools.

Our regulatory audit team performs end-to-end audits – from the point of intake through the determination and notification of determination – using internal policies, State and federal regulations, and URAQ or NCQA requirements. The audit team provides a score based on pass/fail percentage of adherence/compliance to each requirement. We provide an overall compliance score for each month and each quarter. We provide a reason for the errors we find through a table of universal codes, which allows us to trend the types of errors made.

We identify and report the name of the staff member on errors identified to facilitate individual training and coaching, as needed. We provide monthly reports and conduct monthly internal staff audits of five random cases. Staff audits ensure internal standard operating processes are followed, in addition to State and federal regulatory guidelines, and to identify any areas of opportunity and provide additional staff coaching where needed.

In addition, clinical leadership provides daily monitoring of cases to assure authorization processes are meeting timeframe requirements.

N.2 Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan. (5 points)

A critical aspect of the UM process is the consistent application of medical necessity guidelines. To ensure the same utilization review standards are maintained by each individual reviewer and promote consistency surrounding the decision-making process, it is the policy of UnitedHealthcare that all clinical staff makes medical necessity decisions based upon national evidence-based guidelines.

We use evidence-based, nationally recognized *MCG* and *InterQual* criteria in our medical management program to assist us in administering health benefits and to assist clinicians in making informed decisions in many health care settings. These tools are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

In accordance with RFP section 8.1.11, UM clinicians follow federal and State-mandated benefit and coverage determination criteria, including making medical necessity determinations consistent with Louisiana's definition as defined in LAC 50:I.1101. We ensure that services are not arbitrarily or inappropriately denied or reduced by:

- Relying on evidence-based, nationally recognized *MCG* and *InterQual* criteria to determine medical necessity and appropriateness of care.
- Developing standardized coverage determination guideline (CDG) policies that facilitate accurate and consistent coverage decisions.

- Reviewing service requests using benefit plan documents, CDGs, *MCGs* or *InterQual* criteria and internal medical policy to determine medical necessity and appropriateness of care.
- Ensuring medical directors and UM staff are qualified to determine medical necessity.
- Providing staff training for clinical reviewers and conducting IRR assessments to establish the consistency of training and guideline application.
- Conducting consistent, evidence-based medical necessity reviews that result in fair and impartial utilization review activities and outcomes.
- Continuously monitoring, evaluating and seeking to improve our approaches, methods and UM process to ensure that our UM policies and procedures, management and oversight promote fair and consistent application of our review criteria.

Utilization management clinicians performing clinical review may request further information from the provider to make a determination. Cases requiring further review for determination are sent to a medical director with appropriate expertise treating the member's condition. The medical director reviews service requests, may perform peer-to-peer counseling to make a determination and consults with the requesting provider, as appropriate. UM clinicians performing clinical reviews ensure:

- Services are sufficient in an amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished and that no less than the amount, duration or scope for the same services furnished to eligibles under Louisiana's Medicaid plan.
- We do not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member.
- Determinations of medical necessity are to be made by qualified and trained practitioners in accordance with State and federal regulations.
- Individuals making medical necessity determinations have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, professional or moral character.
- Individuals making medical necessity determinations attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.
- Only licensed physicians who have appropriate clinical expertise in the treatment of a member's condition or disease make all decisions to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested.
- Individuals involved directly or indirectly in the UM process are not rewarded in any way for issuing denials of coverage or otherwise encouraged to reduce utilization of services in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.

In accordance with RFP section 8.1.8, we give the information required to make medical necessity determinations to providers in our *Provider Administrative Guide* and on

uchconline.com. We provide the medical necessity guidelines to members in our *Member Handbook*. We provide this information to members and providers verbally upon request.

In accordance with RFP section 8.1.9, we have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. If the provider or member did not submit the necessary clinical information for review, our intake staff makes at least one phone and one fax attempt to contact the provider or member and obtain the clinical information. If we receive the clinical information, we conduct a prior authorization review. If we cannot obtain the clinical information, we may task the case to a medical director for review or deny the service request.

Qualifications of the Staff that Determine Medical Necessity

As presented in the following table, UnitedHealthcare has 250 national medical directors, licensed in more than 40 specialties that determine medical necessity in each of our state Medicaid health plans, including Louisiana. The number next to the specialty in the table indicates how many medical directors we have in each specialty that are available to conduct medical necessity reviews.

Specialty Licensed UnitedHealthcare Medical Directors		
Addiction medicine: 1	Osteopathy: 5	Pediatric Endocrinology: 1
Anesthesiology: 4	Pulmonary: 2	Pediatric Infectious Disease: 1
Emergency Medicine: 7	Rheumatology: 1	Pediatric Neonatal-Perinatal: 1
Family Medicine: 48	Neurology: 1	Pediatric Osteopathy: 1
Family Practice: 10	OB/GYN: 21	Pediatric Preventive: 1
Internal Medicine: 90	Ophthalmology: 3	Physical Medicine and Rehab: 1
Cardiovascular Disease: 1	Orthopedic surgery: 1	Plastic Surgery: 3
Emergency Medicine: 2	Osteopathy: 3	Preventive Medicine: 1
Gastroenterology: 1	Otolaryngology: 1	Preventive/Occupational Medicine: 1
Geriatric Medicine: 2	Pain medicine: 1	Psychiatry/Neurology: 2
Infectious Disease: 1	Palliative: 1	Roentology: 1
Oncology: 2	Pediatrics: 28	Surgery: 9

We ensure our medical directors are qualified to conduct medical necessity reviews by ensuring that they:

- Maintain a current non-restricted license to practice medicine in Louisiana
- Demonstrate adequate education, training and clinical experience in a medical or clinical practice setting to use medical appropriateness criteria and other applicable review standards or medical policy
- Have the ability and credentials (for example, Board Certification) to review cases for which a clinical decision cannot be made by the first level reviewer
- Develop and implement clinical (medical or behavioral health) components of UM program.
- Develop clinical strategies to improve UM policies, procedures, processes and outcomes.
- Ensure reasonable availability, within one business day, to discuss clinical determinations with the attending or ordering physician

- Obtain consultations from specialist physicians if indicated
- Oversee clinical decision-making activities of UM staff and are the only one who can deny services
- Develop clinical policies, procedures and programs
- Oversee clinical appeals process and decision making
- Facilitate grand rounds and case conferences

Gathering Medical History for Making Medical Necessity Determinations

As part of the utilization review process, we may request related medical record information from the treating provider or providers for making clinical coverage determinations in compliance with Section 8.11. Staff members conducting clinical review must ensure adequate clinical information is available to conduct the review. We document attempts to obtain the information in the case file and refer the case to the medical director for review and peer-to-peer consultation. We request only the minimum information necessary to make a determination, such as:

- Office or facility medical records
- Consultations, rehabilitation evaluation, clinical exams
- Diagnosis
- History of the presenting problems
- Description of treatment or services being requested for certification
- Related diagnostic results
- History of related treatment and services
- Photographs

Our provider contracts require providers to provide medical history in the requested or required timeframe. Our standard contracts require providers to accept the negotiated rates for services rendered to members. Providers are prohibited from "balance billing" members. Members are only responsible for payment of any applicable coinsurance, copayments, or deductibles. Providers may bill for non-covered services, but only if the provider obtains the member's written consent. A member may not be billed if payment for a covered service is denied due to the provider's failure to follow reimbursement requirements or other plan protocols.

Additionally, we have contractual requirements related to medical record standards (including electronic medical records), how long a provider must maintain medical records, confidentiality and security of medical records, and the timeframe that a provider must give us access to medical records, when requested. Financial penalties may be imposed for non-compliance, as appropriate.

N.3 Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over-utilization) in the utilization pattern of a provider or a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system. (5 points)

Through our UM program, we gather quality measures, prior authorizations, clinical and claims data, and data from providers or subcontractors. As part of our standard utilization review monitoring processes, we continually review and analyze this data so that we can detect and

correct utilization variances (both over and underutilization) against UnitedHealthcare targets and national standards, such as HEDIS.

Utilization management activities support our QM program, which tracks utilization patterns and reports them to our QMC and HQUM. Our QMC evaluates key quality indicators to identify opportunities for improvement and our HQUM monitors clinical quality improvement and UM activities. Our HQUM acts on patterns of over and underutilization across our member population by analyzing the causes of the utilization variance and creating or revising clinical policies, procedures and processes; educating providers; and implementing member outreach programs to address the root causes of the over or underutilization. UM activities also support quality initiatives, such as our provider profiling program, to ensure that we provide the right services to members at the right time and in the right setting.

How Utilization Data is Gathered

Our Strategic Management Analytic Reporting Tool (SMART) data warehouse gathers and stores clinical and claims data, quality measures, prior authorizations, and data from providers or subcontractors. SMART links with and receives data from our clinical management system, CareOne, which provides an integrated, single solution for managing service authorizations for physical and basic behavioral health services. CareOne maintains all service authorization and utilization data in the member record. We use several tools, discussed throughout this section, that analyze utilization patterns using data contained in SMART.

How Utilization Data is Analyzed

Data analysis drives our UM program by identifying improvement areas and priorities, such as a reduction of readmissions and non-urgent ER visits. Using SMART, we define key metrics, and continuously monitor them at the macro level to identify trends across various dimensions. If a trend seems to be varying from the norm, we use standard reports and conduct root cause analysis to identify the cause of such variations. For instance, the root cause analysis of an increase in utilization for a specific diagnosis code, procedure code or provider could be explained by uncontrollable factors (e.g., a flu epidemic) or could lead to actionable items, such as provider and member outreach about use of the ER versus a doctor's office.

Using data gathered and analyzed by SMART, we have created specialized, clinically-integrated, interdisciplinary care teams that take a comprehensive approach to care delivery across the continuum, supported by the tools in our analytics "Tool Box." Dr. Logarbo, our behavioral health medical director, Ms. Rintala, Ms. Young, our HQUM, QMC, executive management and functional managers use the Tool Box to manage over and underutilization across our health plan, including:

- ***Inpatient utilization (medical management) reports:*** Provide a snapshot of monthly inpatient authorizations, breakdown of inpatient authorizations based upon member age groups, inpatient authorization data by programs, grouping of inpatient authorizations based upon total length of stay, inpatient days and admits by facility and month, and top 20 diagnosis codes for inpatient authorizations for the time period selected.
- ***Hospital Benchmarking (Variant Day Analysis [VDA]):*** Provides detailed benchmark analysis of overutilization days by hospital by All Patient Refined Diagnosis-Related Groups (APR-DRGs) at the State or national level. It compares inpatient admissions,

length of stay, admission and readmission diagnoses, and ER utilization to professionally recognized standards of care and performance metrics. The VDA also allows analysis of:

- Length of stay
- Adjusted readmission rate within 30 days
- One-day-stay percentage, short-stay percentage
- Top variant APR-DRGs for opportunity days
  Top variant APR-DRGs for readmissions
- Top APR-DRGs for observation conversions
- New readmission metrics

Our clinical leaders review data from the VDA tool with hospital leaders to identify opportunities for improvement and develop quarterly and ongoing collaborative clinical initiatives to improve performance.

- ***Inpatient Utilization Dashboard:*** Presents days and admits per 1,000 and average length of stay, based upon inpatient authorizations from CareOne. It includes views by health plan, case type, length of stay groups, member age bands, facility and top 20 diagnoses.
- ***UM Scorecard:*** Compares prior year data against current year goals for UM metrics, admits, days and average length of stay, based upon inpatient authorizations from CareOne. The reports provide additional detail on inpatient utilization metrics by various case categories and trend information on readmissions.
- ***Preventive Services Monitoring:*** Monitors underutilization of primary care and preventive services through our Universal Tracking Database (UTD), which maintains information on member compliance with recommended preventive health services.
- ***Significant Episode Cluster Activity (SECA) Reports:*** Provide insight into our super-utilizers by identifying any member scoring 6 or more combined ER visits or admissions in a rolling 6-month period. These members are immediately referred to high-risk case management.
- ***Blended Census Report Tool:*** Provides care coordinators with timely identification and tracking of members in facilities and allows our UM and case management teams to conduct effective end-to-end, concurrent review, discharge planning and care transition planning.
- ***Clinical Data Management:*** CareOne, our comprehensive clinical data management system, provides a holistic view of our members' care management information, including utilization of services authorized, prescription history, health risk assessments, care plans, and care and disease management programs which we share via the portal with providers.
- ***Health Risk Assessment (HRA):*** Provides early identification and stratification of member needs and acts as one component in the UM/care management care plan development and care coordination process.
- ***Clinical Care Guidelines:*** Nationally recognized, best-practice level of care *MCG* provide for a consistent, evidence-based medicine (EBM) approach for clinical reviews. UnitedHealthcare clinical guidelines compliment *MCG*, provide additional EBM clinical guidelines and allow for a consistent, EBM approach for clinical reviews.
- ***Readmission Risk Assessment (RRA):*** Assesses the risk of readmission. The assessment dictates the level of discharge and transition care management (TCM) the member

receives prior to discharge, allowing us to develop care plans that reduce readmissions and to prioritize post-discharge follow-up care.

- ***Maternal Child Health Scorecard:*** Web-based scorecard provides information such as ante partum admissions, UM data, NICU data, average gestation, deliveries, rate of premature deliveries, cesarean section rate, admits/1000, ER visits/1000 and case management enrollment. We use this information to develop and run clinical initiatives that improve prenatal and post-partum management and reduce NICU admissions.
- ***Emergency Room Escalation Report:*** Allows us to show hospitals the propensity to admit members from their emergency department to either observation or inpatient level of care compared to peer hospitals in Louisiana, the region and nationally. We share this data with hospital partners to discuss opportunities to reduce unnecessary costly care

In addition to SMART, we monitor over and underutilization of health care services among our members using several tools that allow us to identify gaps in care (underutilization) and conduct targeted outreach to providers and members to remediate those care gaps, including:

- ***Impact Pro***, our multidimensional, episode-based predictive modeling and case management analytics solution, compiles claims and clinical data from multiple sources, such as laboratory and pharmacy data, and analyzes it to predict future risk for case management services for members who may be at risk for future utilization. Impact Pro guides/drives clinical model population and member-level clinical priorities. It provides data that we share with practices through our Web-based Population Registry. For example, Impact Pro analyzes claims diagnosis and procedure codes to identify care opportunities, such as potential medication interactions, the use of long acting reversible contraceptives and recommended health screenings.
- ***HEDIS in a Box toolkit*** includes many NCQA HEDIS measures focused on delivery of care and provides specifications for the measures. RN clinical practice consultants (CPCs) use the toolkit to help providers understand evidence-based quality performance guidelines for preventive and condition-specific care.
- ***Universal Tracking Database (UTD)*** monitors compliance with preventive and chronic care standards at the member and provider practice level, provides a shared database for use by case management and quality management to educate members and provides the mechanism by which we can track interventions.
- ***MedMeasures***, our NCQA-certified HEDIS software system, provides interim and annual HEDIS rates to enable profiling against HEDIS standards.
- ***Provider Profiles*** contain preventive care, access to care and UM measures. We profile providers and benchmark them across all of our health plans, looking for providers that fall outside the expected range for service delivery. Our Louisiana PAC reviews the data and works with providers to address issues. We also share provider profiles with providers as discussed later in this section.

Tools for Providers to Identify Member Care Opportunities

We give our providers and ACC practices tools to identify care opportunities among their members and conduct targeted outreach to get members the care they need. Through our person-centered, integrated model of care, case managers, providers and ACC practices use these tools, along with comprehensive member assessments, to identify high-risk members and member care

gaps and develop or modify the member's plan of care to ensure members receive needed health care services.

Our ***Population Registry*** gives providers and ACC practices a comprehensive view of the services used by any given care population, reports each member's risk level and identifies evidence-based medicine gaps in care. The Population Registry gives providers a comprehensive *member view* of the clinical history of the whole person, while the *population view* provides lists of members in the practice who need specific follow up and integrates processes and scripts for specific steps. With the implementation of this contract, all contracted PCPs with a panel size of more than 100 members will have access to the Population Registry.

> With the implementation of this contract, we will provide the Population Registry to all contracted PCPs with a panel size of more than 100 members.

View360 allows providers to view HEDIS quality measures through our secure provider portal and BayouCloud. It gives them actionable information to identify members who may be candidates for specific treatments or screenings, consistent with national quality guidelines. View360 tracks month-to-month care and quality information for 49 quality health measures and provides reconciliation features to submit data corrections by health measure to reflect the provider's clinical record of member care history.

How Utilization Data Monitors Utilization Patterns and Assesses Effectiveness

Based on the analysis provided by UM reports, dashboards, scorecards and tools, Dr. Logarbo, Dr. Freed, Ms. Rintala, Ms. Young, our HQUM, QMC, executive management, functional managers, and board of directors continuously monitor over and underutilization across our health plan. This continuous review includes:

- HQUM reviews and analyzes data and reports that allow us to detect and correct utilization variances (both over and underutilization) against UnitedHealthcare targets and national standards.
- Monitoring underutilization of services (e.g., health screenings) through care management and prevention and wellness using submitted claims, encounters, laboratory and pharmaceutical encounters.
- Identifying the causes of utilization variances and creating or revising clinical policies, procedures and processes or developing strategic initiatives to combat aberrant trends
- Providing reporting and data analysis to the health plan functional areas, the QMC, the Service Quality Improvement Subcommittee (SQIS) and our leadership.
- Functional managers regularly review and analyze reports to verify we provide appropriate care and services to members that meet their individual needs.
- Generating and analyzing utilization reports through HQUM and QMC meetings where we make decisions about the effectiveness and continuation of programs. Reports include a description of the utilization variance, the intervention, responsible party, evaluation and recommendations or modifications.
- Dr. Logarbo meets regularly with Ms. Rintala, Ms. Young and UM management to review reports and identify trends.
- Daily and weekly UM reporting against performance goals to our executive team.

Additionally, through our provider profiling program, discussed below, CPCs and provider advocates deploy targeted programs, in close collaborative partnership with ACC practices and providers, which ensure members receive the needed screenings and health care services that lead to improved health care outcomes. These interventions include:

- Co-branded letter campaigns with providers to remind members that have not received screenings or health care services to schedule an appointment with their provider.
- Member outreach, in partnership with the provider, to contact members and educate them about the needed screening or health care service and help members make appointments with their provider.
- Co-branded clinic days with providers to provide needed screenings and care to members that have not received screenings or other health care services.

Example of How Our Analyses Resulted in Successful Interventions

When we detect under or overutilization, functional experts analyze the data and develop a member- or provider-specific plan to correct the variance and monitor ongoing performance. If our analysis identifies a systemic problem, we develop corrective actions, such as education for case managers to use during member interactions. If the issue is broad enough, we incorporate the change in our member or provider manuals and newsletters.

For example, through our monthly census reporting and trend monitoring, Dr. Ordoyne, Dr. Logarbo and Ms. Rintala review scorecards detailing acute inpatient days, especially one day stays, and observation days. Our denial reports indicated a significant number of denials of 1-day stays for lack of medical necessity, based on use of *MCG/InterQual* criteria. This guided us to review the underutilization of observation status as an appropriate level of care. Appropriate use of observation is critical as it provides the member with the appropriate level of care in an outpatient setting, which is uniformly more cost effective.

We determined that the cause of the underutilization was due to a lack of knowledge among Louisiana providers about the use of observation. Since Louisiana providers are new to managed care they needed to be educated on managed care in general and the appropriate use of observation. Dr. Logarbo and Ms. Rintala embarked on a campaign to personally visit and educate physicians and nurses on the use of observation level of care as opposed to 1-day inpatient stays. Through these efforts, we have seen a significant increase in and appropriate use of observation status.

How Utilization Data is Reported

We submit UM reporting to DHH in accordance with Section 8.3. This includes quarterly utilization reports of all inpatient and outpatient authorizations by category type. On request we provide reports that include admits per 1,000, acute/NICU average length of stay acute/NICU days per 1,000, acute/NICU readmission rates, ER use under age 21, ER use age 21 or greater, observation rates, PCP visits and specialist visits. We also provide ad hoc reporting for the DHH Quarterly Business review. We will also develop provider profile reporting as discussed later in this section.

PCP Utilization and Quality Profiling

Our PCP utilization and quality profiling program complies with RFP sections 8.12.1 and 8.12.2. It identifies opportunities for reducing variation in practice patterns, improves health outcomes

for members and provides us with a tool to discuss best practices with providers. We partner with providers to implement initiatives that improve the quality of care and service provided to members and we use various tools to track practice-level improvements and celebrate successes. In Louisiana, we have incorporated a variety of techniques to motivate and improve provider performance and improve member adherence with well-care visits:

Provider profiling allows us to identify those quality providers to be retained and recruited. Annual PCP utilization and quality profiles summarize utilization and quality indicators, such as encounters, visits to ERs and hospitals, visits by age range for children, immunizations by age range, and screenings for cervical and breast cancer.

To identify potential over or underutilization, we analyze profile data to identify scores greater than one standard deviation from the mean. We target providers in the lowest quartile for quality improvement initiatives.

- Using RN CPCs to visit providers and share best practices and clinical tools that help providers identify areas for improvement. We have five CPCs geographically dispersed throughout the state.
- Conducting provider outreach with plan leadership and our provider network, member outreach and QM departments to educate providers and review utilization patterns.
- Implementing, in collaboration with PCPs, a high-touch member outreach and intervention programs to encourage members to visit their PCP for needed screenings. For example, we developed a chlamydia screening campaign that conducted member outreach (through CPCs) to educate members about the screen and help members make screening appointments with their provider. The campaign contributed to an **8.21 percent improvement in chlamydia screening rates** in measurement year 2013 compared to measurement year 2012.
- Providing service reminder notifications to members via mail and phone to remind them about their HEDIS services. In 2013, **we sent 12,056 mailers and made 86,501 automated phone calls** to remind Bayou Health members they need to come in for service (e.g., child well visits, diabetes screening and women's health screening).

We have developed and implemented standard QM and performance policies that provide guidance for monitoring over and underutilization of services. We conduct provider profiling in compliance with Section 8.12.1; identify PCPs operating outside of peer norms; and identify utilization, prescribing patterns or quality of care issues. We use provider profiling to give providers data and information that gives them insight into their practice patterns and opportunities for improvement. We work with providers to take advantage of these opportunities through partnerships to reach our members and bring them in to see their PCP for care and we establish systems for tracking when members are due for services. The goal is to improve member health outcomes by ensuring all needed preventive and chronic care services are rendered per established clinical practice guidelines.

In collaboration with Dr. Logarbo, physician advocates scheduled meetings with key private sector facilities in the public-private partnership to discuss transition.

Collaborating to Implement our Provider Profiling Program

Under the leadership of Dr. Logarbo, Ms. Young and Ms. Rintala, our provider profiling program is a collaborative effort among several key functions, including leadership, provider network, QM department, member outreach and health care economics.

Health Plan Leadership: Dr. Logarbo provides oversight of our provider profiling program. Additionally, Dr. Logarbo and Ms. Golenor attend quarterly provider meetings, established by our provider advocates, where they discuss HEDIS outcomes, educate providers on our quality programs, share utilization data and discuss utilization patterns.

Clinical Practice Consultants (CPCs): Our five Louisiana-based CPCs go into the field to conduct monthly meetings with high-volume practices that have significant numbers of members that are not in compliance. They review the non-compliant members with providers and discuss ways we will assist with getting members into care. CPCs provide direction and guidance on clinical quality improvement and management programs including accreditation.

Member Outreach: After CPCs conduct outreach to the provider and identify their member's gaps in care, our member outreach team works with the provider to develop outreach programs targeted to address the needs of members in their practice. They deploy outreach programs in an effort to bring members into the provider's practice to receive needed services.

Provider Advocates: Provider advocates conduct frequent meetings to discuss operational issues, such as resolving claims issues. They also setup quarterly meetings with high-volume providers and key staff members (e.g., quality, member outreach and senior leadership) to discuss HEDIS outcomes, educate the provider on our quality programs, share utilization data and discuss utilization patterns.

Health Care Economics Team: Our health care economics teams develops the tools and reporting, such as MedMeasures, Universal Tracking Database and View360, to develop provider profiles and work with our providers to improve member health outcomes and address member gaps in care.

Continuous provider touch points include conducting statewide cross-functional team meetings to introduce providers to our provider advocates and quality, member marketing and health services teams.

Developing Provider Profile Reporting to Improve Quality of Care and Service

We profile PCPs to ensure statistically valid results for monitoring the performance of the provider network, developing improvement actions and conducting effective peer-to-peer comparisons. We profile providers by examining clinical and claims data, such as ER visits, hospital readmissions, lab and pharmacy encounters, claims, in and out-of-network specialty referrals and utilization by high-risk members. Measures incorporate clinical, administrative and member satisfaction indicators, such as inpatient utilization, underutilization of preventive services and insight into super-utilizers.

We monitor HEDIS measures, including CIS-Childhood Immunization Status; LSC-Lead Screening in Children; BCS-Breast Cancer Screening; CCS-Cervical Cancer Screening; CDC-Comprehensive Diabetes Care (LDL screening, HbA1c screening, nephropathy screening, retinal eye screening); AWC-Adolescent Well Care Visits; ASM-Use of Appropriate Medications for People with Asthma; Weight Assessment; W15-Well Child Visits in the First 15 Months of Life; W3-6-Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life; and adolescent well care visit and childhood immunization status.

We also monitor obstetrician (OB) performance measures in Appendix J, such as cesarean rate for low-risk first birth women, behavioral health risk assessment (for pregnant women), frequency of ongoing prenatal care, percentage of low birth weight births and timeliness of prenatal care.

In addition, we track utilization variances and develop provider profiles using various reports, such as:

- High Utilizer reports that identify members using significant health care services
- Provider claims scorecard, which shows the last six quarters of various utilization measures
- Ad hoc reports that present members due for services to support our CPC provider education
- Provider reports supplied as part of our ACC program
- Gaps in care reports provided to practices through View360

Our CPCs are native Louisianians and located throughout the State so they are familiar with local issues and local providers. We have five Louisiana-based CPCs including:

- Tanika Hearns, CPC lead, Baton Rouge
- Karen Grevemberg, Lacombe
- Trenesser Smith, LaPlace
- Sherri Metoyer, Shreveport
- Diana Shirley, Lake Charles

Additionally, we will produce provider scorecards at least twice annually. We distribute the results of provider profiles to PCPs at the individual and/or practice level, depending on the size of the practice's assigned membership. The provider profile provides a snapshot of provider utilization patterns and quality scores. This is accompanied by a list of non-compliant members which details the need and measure for outreach – inclusive of all measures listed on the profile.

Our process, in addition to closing gaps in care, provides critical feedback and education to providers with support from the CPC team. It rewards high performers and help providers with lower scores gain the skills and understanding to move to a higher level of performance. Our experience is that sharing this data bi-annually provides an opportunity for our participating PCPs to view their performance in comparison to others in the network in measures of both utilization and quality. These scorecards provide an additional opportunity for further dialogue between our clinical staff and network practitioners related terms of improvement in quality performance.

Using the Results of PCP Profiling to Improve Quality of Care and Service for Members

Twice yearly, we will distribute the results of provider profiles to PCPs. Profiles are generated for PCPs with more than 100 UnitedHealthcare members. The provider profile provides a snapshot of provider utilization patterns and quality scores. This is accompanied by a list of non-compliant members which details the need and measure for outreach – inclusive of all measures listed on the profile. Our process, in addition to closing gaps in care, provides critical feedback and education to providers with support from the clinical practice consultant team. It rewards high performers and helps providers with lower scores to gain the skills and understanding to move to a higher level of performance.

Our secure provider website and BayouCloud give providers access to comprehensive plan and member-specific information, including View360 data. Additionally, we mail annual HEDIS reports to providers, such as the View360 Patient Opportunity Summary, which gives providers an annual report that helps them identify members who may be candidates for interventions based upon NCQA criteria.

Reviewing Quality Outcomes and Educating Providers at CPC Meetings

Clinical practice consultants conduct regular meetings with providers to analyze and review quality outcomes and educate providers on clinical guidelines and HEDIS requirements. They

use a variety of tools and materials, such as our *HEDIS in a Box* educational toolkit, to illustrate evidence-based quality performance guidelines for preventive and condition-specific care. CPCs:

- Discuss non-compliant members with providers and help identify interventions with these members.
- Provide direction and guidance on clinical quality improvement and management programs including accreditation.
- Conduct chart review for coding validation to ensure documentation encompasses member's conditions and compliance with applicable quality, HEDIS, NCQA and State initiatives.
- Review medical records to evaluate compliance with State medical record standards and help practice staff identify opportunities to improve their documentation and coding of clinical care rendered.
- Educate provider and office staff on various topics, such as billing and encounter submission, HEDIS specifications and State regulatory requirements related to quality.
- Conduct year-round reviews of provider medical records to identify HEDIS-compliant services delivered to members that have not been captured by an analysis of claims data.
- Document the presence of information that conforms to accepted standards of medical practice, which includes evidence of continuity and coordination of care.

CPCs have worked with providers statewide to:

- Implement the statewide HEDIS roll out
- Introduce a State-sponsored program, LaHart, to OBGYN practices statewide.
- Introduce the network resource team as a new, additional resource.
- Drive targeted outreach to providers with a focus on EPSDT, accuracy of claims submission and ensuring profile accuracy on Medicaid website

Discussing Operational Issues and Strategic Planning at Provider Advocate Meetings

Provider advocates routinely conduct meetings to discuss operational issues with high-volume providers to discuss HEDIS outcomes, educate the provider on our quality programs, share utilization data and discuss utilization patterns. Health plan leadership, such as Dr. Logarbo, may attend the meetings to discuss strategic initiatives, such as identifying interventions with members that may be appropriate to the issues members are facing with a particular provider.

Addressing Quality of Care Issues

We monitor provider quality of care issues by tracking, trending and profiling provider-level data (e.g., complaints and grievances) through our QM program. Monitoring this data may identify a situation where the quality of the care rendered is a concern or may indicate aberrant practice patterns. A single quality of care investigation may trigger a review of provider data from these sources or a focused study or audit.

When the monitoring of individual situations or aggregate data results in the identification of what appears to be a quality of care concern, that information is brought to our PAC. Chaired by Dr. Logarbo and comprising participating primary care and specialty network physicians, the PAC reviews quality of care cases and data and determines if care is being rendered in accordance with standards of care for the practice of medicine in Louisiana. If the PAC identifies poor quality of care is being rendered, it can take a variety of actions, including monitoring the provider, requiring continuing education, requiring a corrective action plan, or moving to terminate the provider from participating in the network.

Addressing Inappropriate Over and Under Utilization

Our HQUM routinely reviews data for services that are historically over or underutilized (e.g., sexually transmitted infections [STI] screenings, use of long-acting reversible contraceptives). The HQUM acts on patterns of over and underutilization by creating or revising clinical policies, procedures and processes; educating participating providers; and implementing member outreach programs. In this way, we monitor aggregate data at the provider or population level to identify opportunities for improvement in the quality of care rendered to our members.

PCP Utilization and Quality Profile Reporting

In accordance with Section 8.13, we submit a quarterly PCP profiling report that tracks quality measures defined by the State. We also submit an annual summary of the quarterly reports. The reports track member utilization, by provider, including the number of members, specialist referrals, low-level ER visits, mid-level ER visits, high-level ER visits, hospital admissions, lab services, radiology services, medications and members with more than 12 office visits.

In accordance with Section 8.12.3, we will develop quarterly individual provider profile reports that include a standard set of utilization metrics and HEDIS measures selected based on the measures of most importance to DHH, such as utilization of out-of-network providers, specialist referrals, ER utilization, hospital admits, lab services, medications, and radiology services and individual PCP clinical quality performance measures as indicated in Appendix J. Please refer to Attachment H.4 for sample quality profile reports, which include copies of our provider profiling reports for both provider level and the group level profiling.

Medical Record Reviews and Strategy

We conduct medical record reviews in compliance with Sections 8.2.2.9 and 8.2.3-8.2.5. In addition to conducting chart reviews and reviewing practice medical records as part of regular outreach to providers, CPCs conduct medical record reviews at all PCP sites with 50 or more linked members, including practice sites with individual offices and large group facilities.

> In 2013, we reviewed the medical records of 315 PCPs linked to nearly 110,000 members to assess compliance with medical record documentation standards. We also reviewed 1,348 charts with an average PCP compliance score of 93 percent. Through Q2 2014, we have reviewed the medical records of 175 providers. We have also reviewed 834 charts with an average PCP compliance score of 92 percent.

We communicate the medical record standards and the medical record review process to providers in our *Provider Administrative Manual*. CPCs and provider advocates also provide education to providers about the medical record standards and the medical record review process as part of regular outreach to providers.

Clinical practice consultants conduct medical record reviews with each PCP site at least once in a 2-year period. CPCs review five to 10 records per practice at practices with five or fewer PCPs and review three medical records for each PCP at practices with more than five PCPs. After each medical record review, CPCs hold an exit conference with the provider to give feedback about their compliance with medical record standards and educate providers about medical record documentation requirements. CPCs provide an exit conference document that gives written detail about any deficiencies and opportunities for improvement. Providers must achieve a score of at least 90 percent to be in compliance with medical record standards.

If the PCP receives a compliance score of less than 90 percent, CPCs conduct additional medical record reviews by reviewing an additional five records to see if they can reach the 90 percent requirement. If they cannot reach the 90 percent standard, the CPC conducts an exit conference to give feedback about the issues with the provider's medical records that are leading to non-compliance and educate the provider about medical record documentation standards. The CPC also connects the provider with tools, such as View360, that helps the provider achieve and maintain compliance. CPCs then schedule a 3-month follow-up review and re-review medical records.

For each medical record review, CPCs select cases to review using our member-level database (MLD) that lists all members by provider. The CPC reviews the MLD to determine which members are actively seeing the provider and randomly selects the cases of active members. CPCs pick additional cases to review, if needed, to determine if the provider meets the 90 percent standard as previously discussed.

Clinical practice consultants use our Louisiana medical record review audit tool to track provider compliance with State medical record documentation standards. We have developed a revised medical record review audit tool to support State reporting requirements and streamline the audit process to reduce the time required for the CPCs and providers to complete the audits. We will submit our revised audit tool to the State for approval and propose to implement the tool February 1, 2015. The revised audit tool allows CPCs to verify compliance with the following:

- Procedural elements (e.g., medical record is accurate and legible and medical record contains patient identifying information, including date of birth, sex and legal guardianship, if applicable)
- Medical and surgical history is present
- Preventive services and EPSDT (e.g., evidence of current age appropriate immunizations and documentation of appropriate lab testing, including mandatory lead screening)
- Full documentation of each member visit (e.g., chief complaint or purpose of the visit and timeframe for follow-up visit as appropriate)

We report our audit results to the state quarterly.

During our annual HEDIS audit we work with high-volume providers to access their electronic medical records to assess the provider's compliance with services that affect HEDIS measures, such as EPSDT, preventive measures, well-child, well-women and disease-specific measures, such as diabetes and COPD. Electronic medical record review decreases provider office traffic, reduces provider administrative burden, allows the provider to focus on members and reduces provider costs.

We are evaluating the feasibility of conducting medical record reviews using provider electronic health record (EHR) systems in a similar manner. This would also provide more efficient year-round reviews for HEDIS and State incentive measures. Although the medical review audit process only applies to PCPs, we are considering a similar program for OB providers to track performance against State incentive measures (e.g., cesarean rate for low-risk first birth women). Our clinical action workgroup is evaluating this program and developing a strategy to implement it in Louisiana.

N.4 Describe your plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to DHH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions. (5 points)

Our goal is to ensure members receive high-quality care, at the right time in the most appropriate setting and from the most appropriate providers. We have oriented every aspect of our health plan operations to assuring that members receive the care they need, while avoiding overuse, underuse and inappropriate use of health care services. All of our activities are driven by our person-centered care vision, which:

- Identifies members or populations with the most significant health issues and whose conditions are most responsive to case management intervention using predictive modeling
- Provides patient-centered solutions that are not restricted to a facility, specialist physician or primary chronic disease
- Integrates medical, behavioral and social care
- Provides a mix of health services and community-based services, including social agencies, housing and transportation
- Leverages the resources of complex case management, ACC practices and health homes, and multidisciplinary teams to address the needs of super-utilizers and improve outcomes
- Integrates super-utilizer programs targeted to high-risk members or populations that have unique, chronic or complex needs or conditions (e.g., diabetes, asthma, HIV/AIDS and sickle cell disease)

We developed a performance improvement project PIP focused on reducing inappropriate ER use for members with asthma. In partnership with Our Lady of the Lake and the HEAL project, we enrolled 53 children in intensive asthma case management.

Asthma interventions included use of an asthma management protocol, engagement with community-based organizations to initiate asthma disease management programs, engagement with the schools, member interaction and member education on environmental triggers for asthma.

Overall, ***costs were lower post-enrollment*** versus pre-enrollment. ***Inpatient costs were significantly lower*** and PCP visit and prescription costs were higher, which are all indicators of well managed patients with asthma.

Our approach to providing member care in the most appropriate and cost-effective setting is based upon the following elements:

- ***Analyzing data*** contained in our claims system and clinical systems to identify high-risk members and populations and identify member care opportunities.
- ***Our person-centered, integrated model of care*** improves member outcomes by coordinating services for members who will benefit from a case management level of care.
- ***Our Accountable Care Community (ACC) program*** aligns with DHH's goal to reduce the rate of avoidable hospital stays and readmissions and is advancing our efforts to drive member engagement and improve health care quality and outcomes.
- ***Tools, such as BayouCare and our Population Registry,*** provide case managers, providers and ACC practices near real-time access to actionable information, including admit, discharge and transfer (ADT) data to target members with timely and relevant

interventions that reduce adverse events, improve quality and access to care, and increase proactive care for high-risk members.

- ***Engaging Providers*** to promote seamless delivery of high-quality health care services by identifying care opportunities and ways to collaboratively conduct outreach targeted to meet the needs of members with gaps in care and bring these members into the provider's office to close gaps in care.
- ***Implementing targeted programs to address inappropriate or high utilization of services*** that ensure that we provide the right services to members at the right time and in the right setting by addressing member conditions that lead to inappropriate utilization.
- ***Improving access to care*** through programs that connect members to clinical resources 24 hours a day, 365 days a year and expand primary care service, giving members access to health care services after hours so they can avoid using the ER to receive non-emergent care.

Identifying High-risk Members and Member Care Opportunities

Through data analysis, we identify members that are at high risk of inappropriate utilization of services using a variety or reports and dashboards. For example:

- ***Significant Episode Cluster Activity (SECA)*** reporting provides us with insight into super-utilizers by identifying any member scoring 6 or more combined ER visits or admissions in a rolling 6-month period.
- ***Variant Day Analysis (VDA)*** reporting provides weekly, monthly and quarterly reports that compare inpatient admissions, length of stay, admission and readmission diagnoses, and ER utilization to professionally recognized standards of care and performance metrics. VDA reporting identifies patterns for members with more than 12 outpatient visits, repeated inpatient stays and excessive ER visits; and identifiers super-utilizers and overutilization of specialty care.

We use tools, such as Impact Pro, our multidimensional, episode-based predictive modeling and case management analytics solution, to compile claims and clinical data from multiple sources, including laboratory and pharmacy data, and analyze it to predict members who may be at risk for future inappropriate utilization or high-risk members. Impact Pro:

- Identifies members that have a history of ER use, repeat hospital admissions, high utilization of medical outpatient services, potential quality of care issues or an indication of multiple providers of services that appear to lack coordination.
- Identifies cohorts of members with multiple chronic diseases and behavioral health issues to support enhanced case management by targeting the highest risk members and gaps in care.
- Identifies members with abnormal utilization patterns. For example, to identify BH conditions, Impact Pro analyzes pharmacy data to indicate the use of atypical antipsychotics.
- Assigns an overall "future risk score" for each member based upon an algorithm, representing the degree to which care or case management has the opportunity to have an impact on the member's health status and clinical outcomes

- Provides clinical (medical and behavioral health) insights into why an individual is at risk; predictions of future expenditures and the probability of one or more hospitalizations; and gaps in evidence-based care, which can be used to design and implement effective case management and provider engagement strategies
- Recognizes members with the full spectrum of diagnoses (e.g., diabetes, HIV/AIDS, depression, anxiety and others) and accounts for the acute and chronic conditions that contribute to a member's level of future risk.

Our Healthplan Manager tool allows us to drill down into claims data and help us understand the data in more productive ways. For example, we can look at areas of high utilization of services, high-cost claims data and ER data to understand the conditions that are leading to inappropriate use of the ER.

Case management staff evaluates this information and identifies members with the highest level of risk for further assessment. Using the overall "future risk score" assigned to each member, care managers identify members who are most likely to benefit from interventions to reduce inappropriate use of health care services, such as enrollment in a disease management program or implementing education campaigns to encourage members to visit their PCP to address conditions that are leading to the inappropriate use.

We evaluate ongoing risk through service utilization triggers, practitioner referrals and sophisticated claims analysis. Through careful risk profiling, we have an early warning system to identify members who are at risk for requiring higher levels of care at a later date. By reaching out to these members, we can provide the services needed to support optimal health in the setting of the member's choice.

Providing Services to Members through our Person-Centered, Integrated Model of Care

Our person-centered, integrated model of care delivers a full range of covered and non-covered services our members need into a seamless, holistic experience of care that improves outcomes, enhances member quality of life and reduces the likelihood that members will use health care services inappropriately. Care coordination, case management and chronic care management become points on a continuum of care whereby we deliver the right care in the right setting at the right time. Members may move between care coordination and a more intensive level of chronic care coordination or case management over time as their needs, preferences and the severity of their condition or conditions changes.

We place members into a model of care that is best suited for their needs through individual member engagement, population segmentation and risk stratification based upon our Impact Pro predictive modeling tool. The criteria we have established for case management includes members or populations that:

- Are identified as high risk (most vulnerable) or who have unique, chronic or complex needs or conditions (e.g., sickle cell disease, chronic pain management and bipolar disorder)
- Are at risk for developing a high-risk condition or who are at risk of hospitalization within the next 60 days according to Impact Pro risk stratification
- Have had two or more hospitalizations in the past six months with the same or related diagnosis or multiple ER visits in the past six months

- Have medication management-related issues
- Are at risk for experiencing a high-risk pregnancy
- Are high-utilizers (top 3 percent) with frequent or inappropriate ER utilization and inpatient stays
- Are identified by members of the health care team, such as PCPs, specialists, the State's SMO and UnitedHealthcare team members

Our person-centered approach to case management and chronic care management engages and empowers our members and their families and caregivers, in collaboration with ACC practices, physicians and other health care professionals, to effectively:

- Identify member conditions and associated risk factors and co-morbidities
- Understand the member's needs, goals and preferences for care delivery
- Develop a plan of care that includes flexible health care services to meet the member's needs, goals and preferences
- Collaborate with providers, the State's SMO and other members of the interdisciplinary team to deliver health care services based upon member-specific physical, behavioral and social needs
- Engage members through the intensive feet-on-the-street efforts with case managers and community health workers
- Ensure member choice, protections and access
- Meet the individual, cultural and linguistically diverse needs of all members
- Coordinate member care across the delivery system and care continuum

Dr. Logarbo is a member of the DHH committee on ER reform and working with the State to develop ER reform guidelines to decrease inappropriate use of ER. We have proposed increasing after-hours reimbursement to PCPs to deter ER use by their members, which the committee has taken under consideration.

We have also proposed reinstituting the ER referral process, which is highly requested by providers. We will work through LAHP to collaborate with other MCOs to determine if this can be implemented consistently across all plans.

We commit to implementing reforms recommended by the committee on ER reform.

Accountable Care Community (Expanded Medical Home) Program

We contract with qualifying practices in total cost and quality of care for an attributed population. These value-based contracts focus on improving access to care, decreasing non-emergent ER, avoiding inpatient stays and proactively managing high-risk cohorts. **This program expands the patient-centered medical home to community integration with hospitals, specialists and behavioral health across the continuum of care**.

Our ACC program aligns with DHH's goal to reduce the rate of avoidable hospital stays and readmissions and is advancing our efforts to drive member engagement and improve health care quality and outcomes. For members in an ACC practice, we have already seen double-digit decreases in ER, inpatient hospitalization and readmission rates, including:

- UnitedHealthcare Louisiana ACC practices:
  - Inpatient admission rate shows a 15.9 percent decrease, from 101.8/1,000 to 85.6/1,000*

  - Inpatient readmission rate shows 16.1 percent decrease, from 20.1/1,000 to 16.9/1,000*
  - ER admission rate shows 10.3 percent decrease, from 689.4/1,000 to 618.1/1,000*
- Select Louisiana ACC practices:
  - Practice A - Inpatient admission rate shows a 38.3 percent decrease*
  - Practice B – Inpatient readmission rate shows a 12.2 percent decrease*
  - Practice C- ER admission rate shows a 18.7 percent decrease*

  *All data compared from CY2013 actual versus April 30, 2014 actual

In June 2012, we launched a first-of-its-kind ACC program in Louisiana with The Green Clinic – a multi-specialty clinic based in Ruston, Louisiana, comprising more than 1,800 of our members. We also launched an ACC with Dr. JD Patterson, a solo primary care practitioner based in Monroe, Louisiana, comprising more than 1,100 of our members. Louisiana ACC practices have now grown to 18, consisting of more than **56,574 members statewide.**

Our model includes high-touch collaborative supports provided by transformation consultants and community nurses, who facilitate practice transformation to collaborative and accountable care, and review quality measures and identify opportunities for improvement. Community nurses and transformation consultants routinely educate ACC practices about population health intervention requirements and any member changes noted by community nurses. Specific ACC practice supports provided by transformation consultants and community nurses include:

- ***Transformation consultants***, who live within the community, are assigned to specific ACC practices and assist in each practice's development as an expanded medical home. Using practice-specific real-time hospital data, real-time authorization data and claims-based data, transformation consultants monitor each ACC practice's performance on a regular basis and provide formal performance updates to each practice. In addition, transformation consultants complete clinical and workflow assessments of each practice to facilitate optimal population health management processes.
- ***Community nurses***, who live within the community, are assigned to specific ACC practices and collaborate with ACC practice case managers to review members' risk factors, preventive tests, services and physician-recommended interventions and then follow up with external referrals to confirm the member is following those recommendations. Community nurses also ensure that all population health interactive interventions occur by leveraging themselves and practice clinical staff, including face-to-face support, for healthy behavior changes (e.g., smoking cessation and weight loss).

We partner with ACC practices and providers to:

- Identify high-risk members and manage them closely
- Reduce ER utilization
- Reduce inpatient admissions and readmissions
- Improve access to care

We support our ACC practices with our BayouCare electronic collaborative care coordination system and our Population Registry (including Automated Care Transitions software), described below, which identify gaps in care and provide real-time access to actionable information to target members with timely and relevant interventions, such as follow-ups within seven days of inpatient or ER discharge.

We establish aspirational goals with the practices to improve same day visits by 50 percent, decrease admissions by 20 percent and reduce non-emergent use of the ER by 50 percent. We follow a plan-do-study-act (PDSA) continuous process improvement approach to achieve the goals, reviewing performance and creating improvement each month in our meetings with practices and related high-volume discharging hospitals.

Community nurses work with ACC practices and practice staff to provide training on the use of these tools and coordination activities for which the ACC practice is accountable. Additionally, using data contained in Impact Pro, BayouCare and the Population Registry, we determine if members assigned to ACC practices are receiving all required interactive interventions from the practice.

Our goal over the contract period is to have 80 percent of our providers in value-based arrangements that span from pay for performance (quality agreements) to ACC arrangements (total cost and quality of care). We will work with all safety-net providers and physician-hospital organizations (PHOs) to establish ACC arrangements with practices of more than 1,000 attributed members. For those with less than 1,000 members, we will work with these practices to aggregate them into larger units to reach more than 1,000 members and contract with the aggregated entity as we have done in New Jersey with Dr. Jeff Brenner's renowned Camden Coalition (super-utilizing hotspotting).

Integrating the Network with BayouCare

Through BayouCare, our integrated, secure, cloud-based collaborative care coordination tool for **super-utilizers** we establish an integrated plan of care accessible and updateable by the entire interdisciplinary care team across the network. We will provide case managers, PCPs, psychiatrists, specialists, the State's SMO and the member with an integrated plan of care. BayouCare includes:

BayouCare allows our clinical team, PCPs, ACC practices and the SMO to conduct relevant and timely member interventions that improve member health outcomes and experiences and reduce inappropriate use of health care resources.

- A shared, dynamic, coordinated plan of care that integrates medical and behavioral data and social service and personal information (e.g., likes, dislikes, fears) and securely shares vital member information across the interdisciplinary care team
- A variety of publically available, valid and reliable assessment tools and a notification process that reminds the team to perform assessments at specific time intervals
- A person-centric view of issues, goals, interventions and documentation (e.g., medications, service dates/outcomes and progress/case conference notes) across all encounters
- The right information at the right time (e.g., ADT notifications) to identify opportunities to engage members
- An full range of secure communication and collaboration tools that allow the care/case manager to communicate with the member's PCP and behavioral health providers
- Care/case manager dashboards that monitor and track various components of current caseloads

Reducing Inappropriate Use with the Population Registry

Our Web-based Population Registry helps reduce inappropriate use of health care resources by providing a comprehensive view of the services used by any given care population, reporting each member's risk level and identifying evidence-based gaps in care.

Providers and ACC practices receive ADT information from the Louisiana Health Information Exchange (LaHIE) and direct hospital data feeds (we are working with the Greater New Orleans Information Exchange to exchange this data) and use this real-time data to improve hospital transitions, assist with coordination and continuity of care, and improve health outcomes for our members who transition between care settings through our Automated Care Transitions tool. The Population Registry and Automated Care Transitions tool improve the timely flow of information so that providers, case managers and ACC practices can quickly and effectively address the health care needs of members transitioning from inpatient facilities to care in the community.

> We are the only MCO with an active contract with the Louisiana Health Care Quality Forum (LHCQF), the entity that built and supports Louisiana's health information exchange, known as LaHIE. We currently receive daily admit, discharge transfer (ADT) information from LaHIE and multiple independent hospitals and share it with our providers through our Population Registry tool to improve hospital transitions, assist providers with coordination and continuity of care, and improving health outcomes for our members who transition between care settings.

With the implementation of this contract, we will expand access to the Population Registry to all contracted PCPs with panel sizes greater than 100 members, increasing access to actionable data and patient management tools.

Engaging Providers to Improve the Quality of Care and Service Provided to Members

We engage providers, including those providing carved-out services (e.g., dental and behavioral health), to collaboratively provide case management services, identify opportunities for provider improvement and develop outreach targeted to meet the needs of members with gaps in care. Through our provider profiling program, CPCs work with providers to improve the quality of care and service provided to members by conducting regular provider meetings to analyze and review quality outcomes, review care gaps for their members and educate providers on clinical guidelines and HEDIS requirements. They use a variety of tools and materials to illustrate evidence-based quality performance guidelines for preventive and condition-specific care.

> We have established ADT data feeds with nearly 70 hospitals and medical centers statewide.

Through provider advocates we regularly engage providers to discuss operational issues and HEDIS outcomes, educate providers on our operational procedures and quality programs and share utilization data and discuss utilization patterns. Health plan leadership (e.g., Dr. Logarbo) attends some of these meetings to discuss strategic initiatives, such as identifying interventions with members that may be appropriate to the issues members are facing with a particular provider.

Targeted Programs to Address Inappropriate or High Utilization

As part of our ongoing clinical strategy to address members with inappropriate or high utilization of services, we will deploy targeted programs, in close partnership with case managers, providers and ACC practices. Collaborative partnerships and coordination between the member, health

care professionals and support systems are necessary to develop the targeted interventions and health care goals that lead to improved health care outcomes. As discussed in the following sections, we propose to implement several programs that reduce inappropriate ER use and improve access to health care services.

Reducing Emergency Room Utilization

As presented in the figure below, our ER Utilization Reduction program builds on all of the components of our program, such as using data to identify care opportunities and high-risk members; engaging community health workers to outreach to members; and providing real-time ADT data to our clinical team, providers and ACC practices using our Automated Care Transitions tool. This enables them to provide timely interventions when a member uses the ER and implement our person-centered model of care, which manages member care and engages case managers, social workers and community health workers to conduct outreach to members that have recently used the ER. Community health workers are a key component of our approach, providing “feet on the street” to conduct outreach to members that have recently used the ER and engage these members in activities to reduce the likelihood of future inappropriate ER use.

Identifying Members That May be at Risk

We identify high-risk members, such as members who have unique, chronic or complex needs or conditions; are at risk for developing a high-risk condition; or are at risk of hospitalization within the next 60 days according to Impact Pro risk stratification. We engage case managers, ACC practice case managers and community health workers to conduct outreach to high-risk members to understand the cause of the ER visit and coordinate needed services.

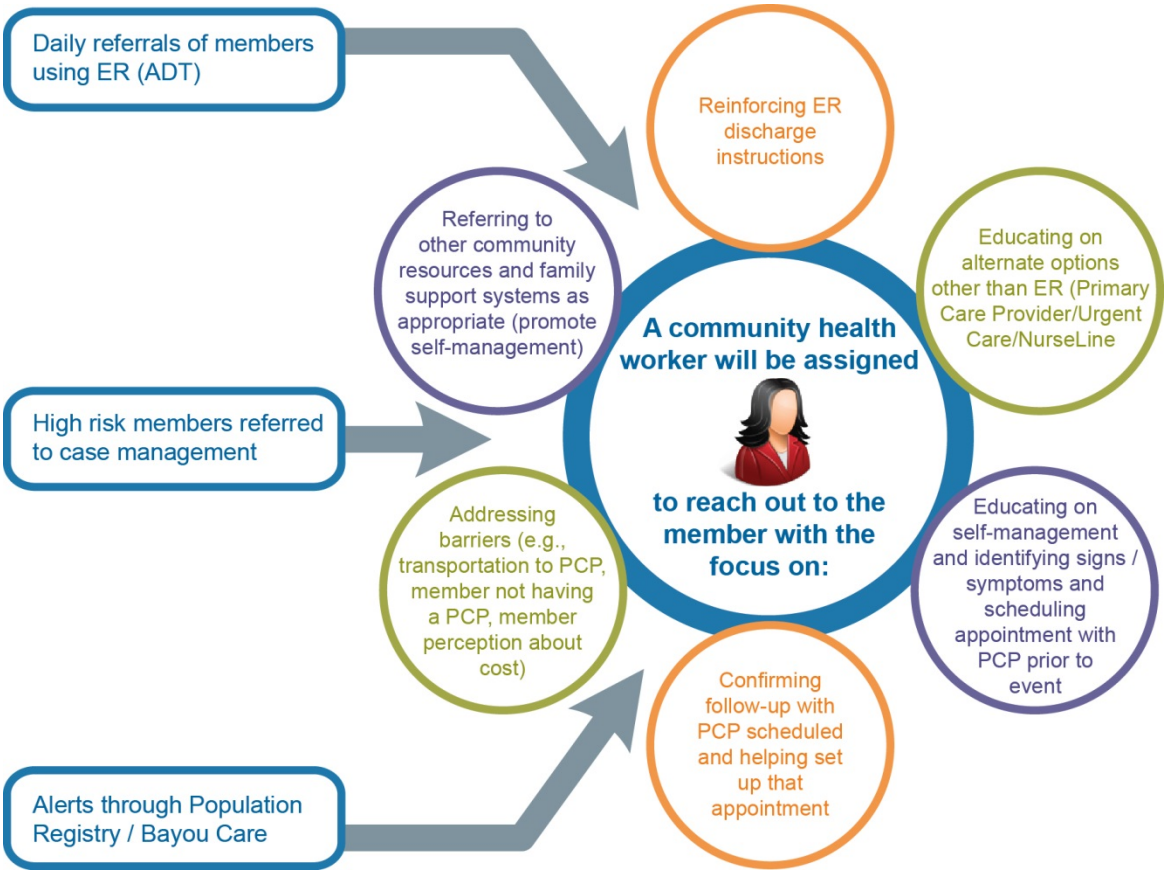


Figure 25. ER Utilization Reduction Program. Our ER utilization reduction program uses data to identify care opportunities and high-risk members, engages community health workers to outreach to members that have recently used the ER and provides real-time ADT data to our clinical team, providers and ACC practices so they can provide timely interventions to manage member care.

Outreach to Members through Community Health Workers

Based on the results of our pilot with Children's Hospital of New Orleans, discussed in the callout box, and as part of our person-centered, integrated model of care, we will engage community health workers to conduct outreach to members that have recently used the ER to:

- Reinforce ER discharge instructions
- Educate members on alternate options to inappropriate ER use, such as visiting their PCP, an urgent care facility or contacting NurseLine for assistance
- Educate members on self-management and identifying signs/symptoms of an event and scheduling appointment with PCP prior to an event that leads to inappropriate ER use
- Help the member set an appointment with their PCP
- Confirm a follow-up visit with the member's PCP is scheduled
- Identify and address barriers (e.g., transportation issues, member not knowing their PCP, member perception about cost)
- Refer members to other programs (e.g., Healthy First Steps for pregnant members), including community resources and family support systems as appropriate

Children's Hospital ER Diversion Pilot

We developed a pilot with Children's Hospital of New Orleans to obtain near real-time data, such as ER diagnosis and ADT information, and using this data, route an ER health coach to members with low level ER diagnoses.

The health coach attempted to contact the member post-ER visit and discuss alternatives to visiting the ER, such as contacting NurseLine, visiting their PCP or going to an urgent care facility. The health coach also stressed that the use of the ER is a source for emergency care only.

As a result of this pilot, we saw a **28.3 percent reduction in ER utilization** and overall costs for the last six months of 2013, compared to the first six months of the year.

Alerting Case Managers, Providers and ACC Practices to a Member's use of the ER

We integrate ADT information into our Automated Care Transitions tool and share this near real-time data with case managers, ACC practice case managers and providers so they know when members access health care services and conduct relevant, timely interventions that improve health outcomes and reduce inappropriate use of health care resources. We will require hospitals to provide ADT information through LaHIE and have already established ADT data feeds directly to us with nearly 70 hospitals and medical centers statewide.

Improving Access to Care

Another approach to ensuring we provide care in the most appropriate and cost-effective setting is to improve access to care through programs that connect members to clinical resources 24 hours a day, 365 days a year and expand primary care service. We do this through a variety of approaches, discussed in the following sections.

NurseLine

We provide ACC practices with information on any members that contact NurseLine or NowClinic.

Already implemented in Louisiana, NurseLine is an effective resource for helping members reduce unnecessary ER use by providing RNs to help members access appropriate medical and behavioral health services 24 hours a day, each day of the year. NurseLine is one of only four nurse advice services in the industry to hold both full URAC accreditation and NCQA certification.

NurseLine RNs help members choose appropriate medical care, find a physician or hospital in their community, understand treatment options, achieve a healthy lifestyle or ask medication questions. NurseLine nurses educate members about their condition and help them improve self-management of their conditions. NurseLine nurses reinforce education about appropriate ER use and help members understand the resources and services available to them and how to access them.

The information members receive is trusted and physician-approved to help guide them through their health care decisions. These nurses receive extensive orientation on each of Louisiana's service areas, languages, service use patterns, transportation challenges and other issues that impact the member's ability to access services.

NurseLine nurses can also facilitate a phone referral to NowClinic, discussed below, which provides members with access to a State-licensed, board-certified, credentialed physician who can address their immediate health concerns and determine the best course of care.

Telemedicine and NowClinic

NowClinic:

- Improves member access to care by providing convenient member access to care 24 hour s day, 365 days per year
- Reduces barriers to accessing care after hours and in underserved and rural communities
- Reduces the need for members to seek care in the ER
- Improves overall cost and quality
- Promotes the right level of care

NowClinic is a 24 hour a day, 365 day per year telemedicine solution that connects members to health care providers via webcam, chat, phone and mobile app. NowClinic improves member access to care by providing convenient member access to acute and episodic care in real-time without an appointment, reduces barriers to accessing care after hours and in underserved and rural communities, reduces the need for members to seek care in the ER, improves overall cost and quality, and promotes the right level of care.

Members can talk with providers and receive diagnosis, education and prescriptions for medications. NowClinic providers are not intended to replace the member's PCP, but to provide improved access to care in rural areas and urgent care and after-hours support. The NowClinic solution includes the following components:

- ***Technology:*** online website that serves as the home for the NowClinic service. It contains general information and access to an enrollment and consultations area.
- ***Provider network:*** board certified, licensed to practice in Louisiana, in-network, general practice providers (e.g., M.D.) who are specially trained to provide online care, available within 15-30 minutes with no appointment.
- ***Member record:*** consult record captures patient diagnosis, prescription, demographic information and email address.

NowClinic providers can treat the following acute and episodic conditions, subject to provider discretion and appropriate technology (e.g., webcam):

Providers can:

- Assist with care from the common cold and flu to wellness and prevention
- Can prescribe, order tests, complete referrals and provide follow-up care as needed

- Acne (mild cases)
- Allergies (rhinitis)
- Athlete's foot
- Asthma (short-term refill – two to three day supply only)
- Bladder infection/urinary tract infection
- Bronchitis
- Cold Sore
- Coughs/cold/pertussis
- Constipation (follow up required)
- Ear infection/swimmer's ear (follow up required)
- Diarrhea
- Diabetes education and support
- Eye infections/pink eye/sty (decrease is visual acuity and eye pain should be seen immediately, video required)
- Fever, chills and runny nose

- General health education and advice
- Gout (video required)
- Headache
- Insect bites, such as spider bites/deer tick bite/Lyme disease (video may be required)
- Sleep and insomnia education
- Lab follow up, short supply/refill
- Laryngitis
- Medication renewal/refill (two day short supply)
- Smoking cessation education
- Nausea
- Pet allergies
- Poison Ivy (video enabled)
- Poison Oak (video enabled)
- Ringworm (video enabled)
- Skin inflammation, such as rash, shingles (video enabled)
- Sinusitis
- Sore throat
- Sunburn
- Tinea Versicolor (video enabled)
- Viral illness
- Vomiting (follow up will be required)

In the future, we will work with the State to consider deploying NowClinic with case managers and community health workers for use with the member in the member's home and local provider offices to provide access to chronic, behavioral and specialty care and to connect the member with the member's local provider through NowClinic. As we have done in other states, we will work with Louisiana to gain permission to encounter non-face-to-face visits.

Access to Urgent Care Facilities

We have developed a network of 13 urgent care facilities throughout the State and will continue to work with providers, including ACC practices, and facilities to expand our network to provide health care services to members after hours. For example, we are working closely with the Children's Hospital Urgent Care Clinics to provide after-hours care through its system of urgent care clinics for members in the New Orleans/Northshore area. Redirecting members to these clinics, which are staffed by pediatricians, will assure that children needing urgent, but not emergent, services after hours will be getting the right level of care.

In other states, such as Tennessee, we have worked with our ACC practices to implement an after-hours access program where each of the practices provides after-hours coverage on a rotating basis. Through our Louisiana PAC, we will review and discuss this approach and additional approaches to provide after-hours care for Bayou Health members.

Extended PCP Office Hours

We will work with PCPs to identify opportunities to provide after-hours care in an attempt to serve the urgent care needs of the member in the provider setting and promote

redirection of care to the PCP and away from the ER. We will reimburse PCPs for providing after hours care if they send in the clinical record of the after hour visits.

Interventions Targeted to Super-Utilizers

As part of our ongoing clinical strategy to address members with inappropriate or high utilization of services, we will deploy targeted programs that address member conditions that lead to inappropriate utilization of health care services and provide access to health care services that reduce the likelihood that members will seek services through the ER.

Dental

We recognize the importance of preventive and routine dental services to the overall health of our members. In our experience in Bayou Health since 2012 we have found that a number of members visit the ER with tooth pain. Because they do not have dental benefits, pain management, often obtained through the ER is their only course of action. We believe that offering a real alternative that addresses the root cause rather than the symptoms will not only decrease ER utilization, but improve quality of life for our adult members. This benefit provides routine exams, x-rays, cleanings, fillings and extractions for UnitedHealthcare Bayou Health members who are ages 21 and older.

Behavioral

We are implementing programs that provide “high-touch” case management for targeted groups of members, including our most vulnerable members and the top 5 percent of utilizers. For members who are identified or stratified at the highest risk for poor health outcomes, our case management program can include face-to-face interaction by a nurse case manager with medical or behavioral health experience and, as a member’s condition requires, a behavioral health coordinator or community health worker. Face-to-face meetings may be used to conduct more in-depth health assessments, develop the individualized plan of care and make changes to the plan over time, as the member’s needs change.

> Under the direction of our behavioral health medical director, we will engage and educate providers on rendering basic behavioral health care in the office setting. Providers may conference with the behavioral health medical director and develop a plan of care for members with these needs.

Additionally, we will provide our PCPs with our Behavioral Health PCP Toolkit that contains assessment tools and links to websites where the most updated behavioral health clinical practice guidelines can be referenced for common behavioral health conditions (e.g., bipolar disorder, schizophrenia, depression, substance abuse and ADHD). It provides links to educational materials and screening tools for common behavioral health conditions (e.g., substance abuse, depression and anxiety disorders) that are quick and easy to administer and score. When providers identify positive screens for any of these behavioral health conditions, they call our dedicated number for assistance in referring members to qualified providers who will offer treatment interventions and coordinate findings and treatment response back to the referring PCP.

The Behavioral Health PCP Toolkit contains links to additional resources for our providers to access information about Screening, Brief Intervention and Referral to Treatment (SBIRT) of individuals who present with potential substance abuse problems. These resources cite evidence that SBIRT interventions are evidence-based and effective, and offer educational material and guidance on how the SBIRT is administered and operationalized, as well as indicate the CPT

codes that providers can use to obtain reimbursement from payers for SBIRT related interventions.

Louisiana Sickle Cell Program

Our sickle cell program identifies all members with sickle cell disease (SCD) to assess and risk stratify those members, enabling prospective outreach and education to the appropriate population. Care and case management services help members with SCD manage their illness leading to improved quality of life and reduced likelihood that members will seek health care services in an inappropriate setting, such as the ER.

Sickle cell program goals include:

- Improved function and quality of life for members with SCD
- Successful transition from pediatric to adolescent and adult condition management
- Measurable decreases in ER visits, inpatient admissions and readmission rates
- Measurable decrease in the overall cost of care for members with SCD
- Improved hydroxyurea adherence
- Reduced episodes of pain crisis and iron overload
- Reduction in ischemic stroke and transient ischemic attacks
- Delayed disease progression

Our national clinical team has significant experience managing the care of members with SCD so they understand the unique needs of these members. We have leveraged the team's expertise to develop an SCD program that enhances our person-centered clinical model by offering timely SCD-specific interventions and resources, tailored to individual patient needs. Our SCD program addresses the challenges unique to each stage of life, from newborn through adulthood, to mitigate disease progression and complications and improve the quality of life for members with SCD. Our SCD expertise includes:

- Associate medical director Dr. Lanetta Jordan, who is a world-renowned expert in SCD, has helped develop our national SCD clinical model. She also participated in the development of national SCD evidence-based guidelines sponsored by the National Institutes of Health (NIH).
- National clinical team has Medicaid experience and hands-on experience in the management of patients with SCD.
- SCD medical director Dr. Paul Monte is American Board of Internal Medicine-certified and has significant experience managing patients with SCD in a hospital setting. Dr. Monte and Dr. Jordan will oversee our national SCD clinical model.
- National SCD expert panel, comprising board-certified experts in treating members with SCD, reviews and updates all clinical components of our model under the oversight of Dr. Monte.

Our national clinical quality team is adopting SCD evidence-based guidelines tailored to the needs of our members, based upon the NIH guidelines (e.g., clinical trials or managing transplants for members with SCD). The team has also developed a pain management process to help SCD members manage their daily pain levels so they are not visiting the ER or being admitted to the hospital. We further discuss this process in our response to RFP question N.6.

To address the needs of Bayou Health members with SCD and tailor our SCD program model to the needs of our members, we have analyzed Louisiana claims and other clinical data to provide us with a better understanding of the prevalence and location of:

- Members with SCD (see below figure)

- Members with SCD that are high utilizers (one or more inpatient admissions or ER visits within a 12-month period) and segmented members by adults and members under 19 (see below figure)
- Providers and specialists with expertise treating members with SCD
- Community resources (e.g., Sickle Cell Disease Association of America chapters throughout Louisiana) that provide support to and advocate on behalf of members with SCD (see below figure)

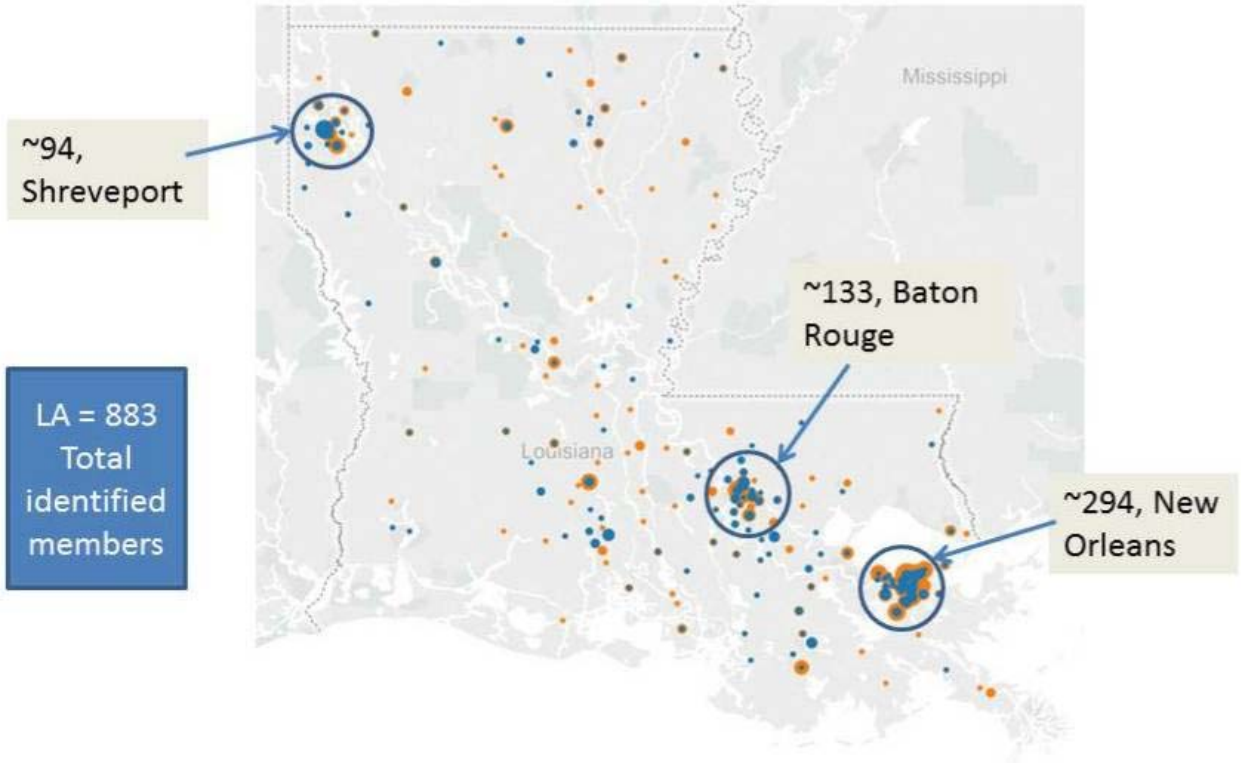


Figure 26. All SCD Members. UnitedHealthcare Datamart, Sept. 1, through Aug. 31, 2013, pulled April 2014; SCD identified using any of the nine diagnosis codes, nine fields, claim $0 paid or greater, 2009 or later.

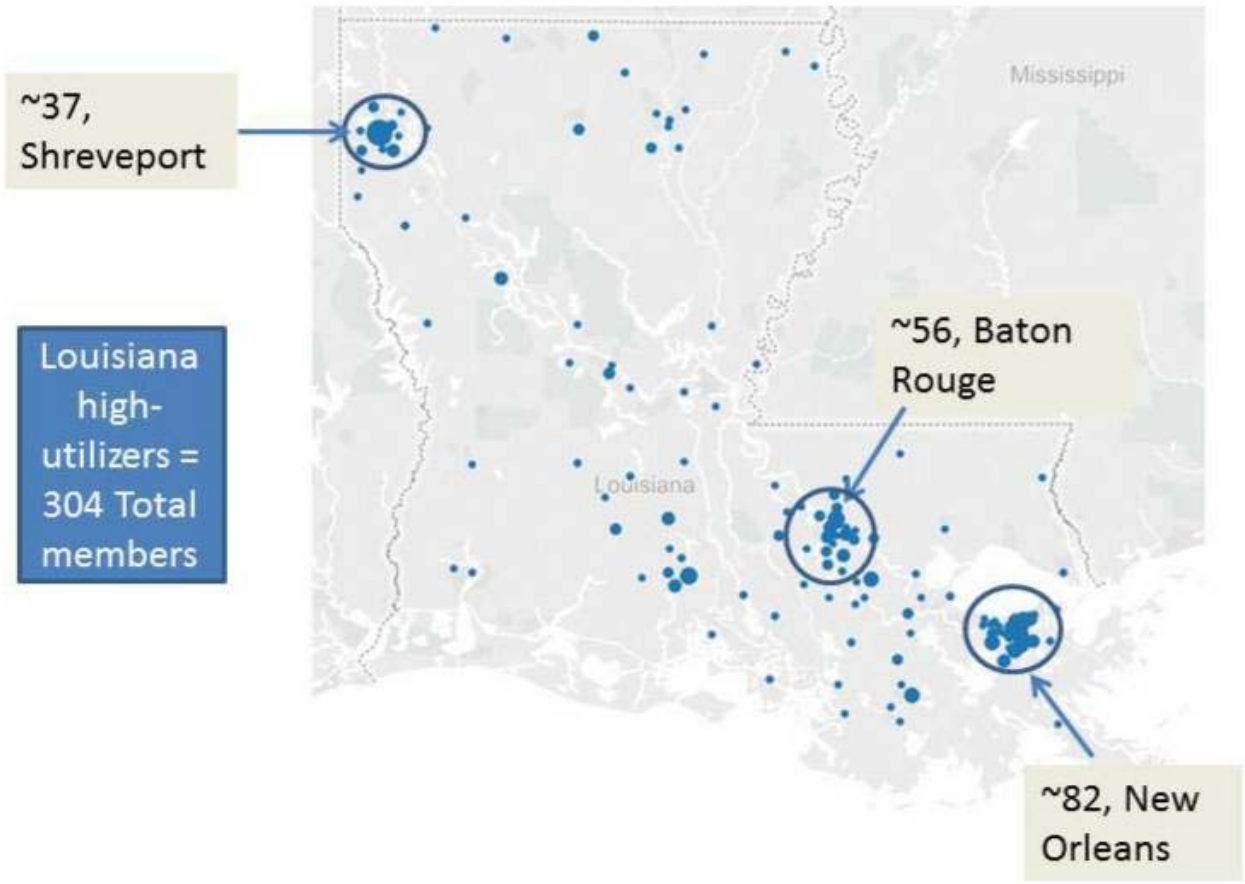


Figure 27. High-Utilizers. High-utilizer has one or more ER/inpatient (any of nine SCD diagnosis codes) within a 12-month study period.

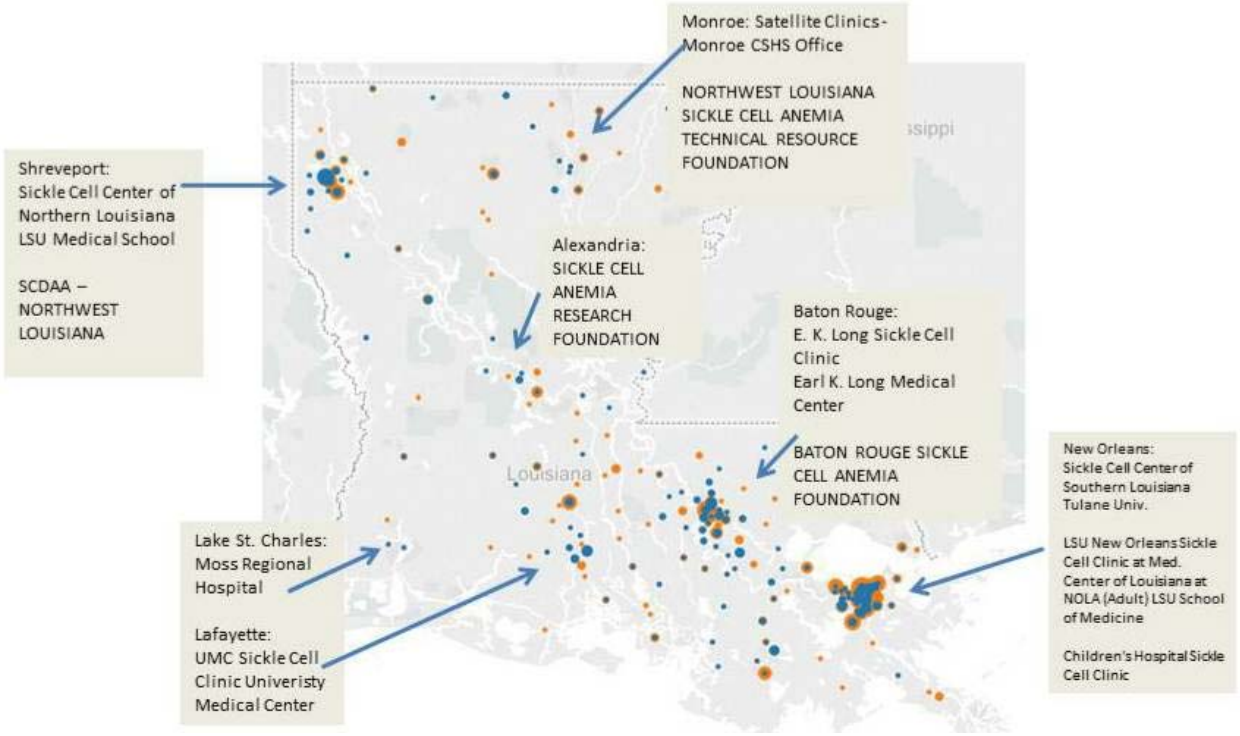


Figure 28. Sickle Cell Support. https://scinfo.org/sickle-cell-clinics-contacts-and-resources#Louisiana.

Using the results of these analyses, we have:

- Developed a case management staffing plan that will provide case managers with SCD experience to manage high-risk members with SCD.
- Performed an initial risk stratification of members and identified high-utilizers.
- Developed job aids, procedures and processes for SCD case managers.
- Developed referral procedures for SCD case managers to refer high-risk members to specialized programs (e.g., behavioral health providers, kidney specialists or transplant specialists). For example, for high-risk pregnant members, the SCD case manager coordinates with the Healthy First Steps case manager to collaboratively manage the member's SCD and their high-risk pregnancy.
- Established relationships with 12 community-based resources (e.g., hospitals, universities and community-based organizations) throughout the State, such as the Baton Rouge Sickle Cell Anemia Foundation.
- Established relationships with providers that are affiliated with SCD community organizations, such as The Foundation for Sickle Cell Disease Research.

In 2014, we implemented a sickle cell outreach program that identified Louisiana members with SCD and provided trained nurses to conduct outreach phone calls. The purpose of the outreach was to provide education and engage the member with a PCP and provider experienced in treating SCD or a specialist that can work with the member to properly manage their condition. We completed the outreach in June. We contacted 366 members and reached and educated 141 members (39 percent). 50 members received written education and 20 members asked to speak with a case manager and were referred to case management.

In addition to these efforts, we are:

- Identifying gaps in our provider network so that we can develop an interconnected network of physicians who are experienced in treating SCD.
- Identifying educational opportunities for PCPs that includes information on how to manage members with SCD (e.g., use of hydroxyurea and penicillin and Transcranial Doppler [TCD] screening). This PCP education is critical to providing PCPs the knowledge to successfully manage the care of members with SCD. For example, TCD screening is a covered benefit that screens for the risk of a stroke. The results of the screening allow the provider to conduct interventions, such as regular blood transfusions, to minimize the stroke risk to the member.
- Developing a Louisiana-specific advisory panel that will be made up of non-clinical members, such as community organizations and caregivers, to understand the unique needs of Bayou Health members
- Working to establish an SCD Center of Excellence in Louisiana, consisting of local providers and specialists with expertise managing SCD patients. This center of excellence will work to improve the care and management of all SCD patients in the State.

Sickle cell program interventions are designed to achieve:

- Early engagement
- Delayed disease progression
- Pain and symptom management
- Prevention of iron overload, stroke, infections, acute chest syndrome, organ failure and other complications
- Identification and treatment of depression

Once implemented in the State, our Louisiana SCD program will enhance our person-centered model of care by:

- Identifying all members with SCD to assess and risk stratify those members, enabling prospective outreach and education to the appropriate population. We identify members through:
  - Analysis of claims and clinical data and risk stratification using Impact Pro.
  - The new member welcome call and health risk assessment (HRA).
- For members identified with SCD, we refer them to our SCD clinical team for a comprehensive sickle cell assessment that will identify member needs and their risk level.
- Engaging low or moderate risk members in care management services that help them manage their illness leading to improved quality of life and reduced likelihood that members will seek health care services in an inappropriate setting, such as the ER.
- Engaging high-risk members (e.g., members experiencing recurring pain crises) in case management through collaboration between a member's PCP and a case manager with expertise in managing patients with SCD or enrollment in an ACC practice with SCD expertise. For practices without this expertise, our SCD case manager will partner with the practice to manage the member's care.
- Implementing a "feet on the street" model to increase member engagement. This engagement will be conducted by our SCD case manager, community health workers and through partnerships with community-based organizations that support SCD members.

- Engaging providers and members at practices, hospitals, schools and community events to provide education, develop relationships and connect members to community resources.
- Implementing local, field-based SCD experts, supported by telephonic experts who help find members, conduct the sickle cell assessment, identify gaps in care, and resolve barriers to care (e.g., transportation issues, member not knowing their PCP, member perception about cost).
- Coordinating with behavioral, pharmacy and other services, such as Healthy First Steps.
- Ensuring development of an effective, individualized plan of care in BayouCare to reduce pain and manage symptoms, including short- and long-term pain management goals.
- Ensuring members have a pain management plan in order to manage their daily pain levels so they are not visiting the ER or being admitted to the hospital.
- Providing patient/caregiver education and support, such as use of hydroxyurea; managing daily life functioning; coping with cognitive functioning issues; understanding how to speak with providers; transitioning to adult condition management, including managing their own care; and empowering members to get what they need to manage their condition from their provider.

Ongoing sickle cell program interventions include;

- Ongoing evaluation and risk stratification
- Creating, updating, communicating and managing an individualized plan of care in BayouCare
- Periodic member assessment
- Monitoring and managing ER and inpatient admissions and readmissions
- Coordinating access to appropriate support services both inside and outside of our provider network
- Patient, caregiver and physician education
- Patient advocacy throughout all stages of the care continuum

Chronic Pain Management Program

Identifying members with chronic pain and providing them with appropriate supports (e.g., pain management) will lower inappropriate utilization because the member will be able to manage their daily pain levels so they are not visiting the ER or being admitted to the hospital. We will identify members that require pain management interventions and are at high risk of needing surgical intervention to relieve pain (e.g., specific cases of degenerative disk disease). Our pain management program ensures that these members are enrolled in case management and have a pain management plan, developed in conjunction with the member's case manager and PCP or ACC practice case manager. We also ensure that these members can be "self-advocates" by coaching them to have the knowledge and confidence to get what they need from their provider to manage their pain. Additionally, we will offer the option of pain management injections as a benefit exception for specific populations, as appropriate (e.g., members with degenerative disk disease).

Helping a Terminal Cancer Patient Manage his Pain

Charles has terminal cancer and is in constant pain. He has tried numerous pain medications, but none has worked. He has told his doctors about his pain, but says they've told him there is nothing more they can do for him.

Charles' case manager worked with his physicians and the medical director of a hospice agency to get Charles approved for hospice care to ensure there was a greater focus on his comfort. The case manager also spoke with the primary care physician about Charles' pain and learned that the doctor had just approved an increase in Charles' pain medications.

Charles is receiving home hospice care, his pain is under control and he has everything he needs. He is very appreciative of his case manager for all her work. He says that if it weren't for her, he believes his pain would still be intolerable.

N.5 Discuss approach you will use to address high STI prevalence by incentivizing providers to conduct screening, prevention education, and early detection, including targeted outreach to at risk populations. (5 points)

We have experience working with providers to address high sexually-transmitted infection (STI) prevalence in the State. For example, as part of our standard utilization review monitoring processes, we conducted data analyses that identified underutilization in chlamydia screenings. Our UM and QM teams collaborated to identify the causes and develop a solution to remediate the underutilization. Our chlamydia screening campaign combined components of our UM program, QM program and provider profiling program, to:

Our data driven chlamydia screening campaign contributed to an **8.21 percent improvement in chlamydia screening rates** in measurement year 2013 compared to measurement year 2012.

- Identify providers with more than 50 members in their panel and with a significant percentage of members that had not completed a chlamydia screening.
- Assign a CPC to engage the provider and identify and overcome barriers to care. In some cases, providers were not aware of in-office screening techniques or proper claims coding for the screening to be counted in HEDIS rates.
- The CPC engaged our quality outreach coordinator to conduct member outreach to educate members about the screen and help members make screening appointments with their provider.
- For minors, the outreach campaign targeted those members who also needed an adolescent well-child visit, demonstrating sensitivity to potential teen concerns about privacy with respect to their sexual activity.

Based on our experience in Louisiana and building on existing programs and partnerships (e.g., our provider profiling program, CPC outreach, Health First Steps, school-based health clinics), we will address high STI prevalence in Louisiana by improving STI screening rates for chlamydia, human papillomavirus (HPV) vaccine for female adolescents, HIV, syphilis and gonorrhea. Our approach includes the following elements:

Identifying high-risk members and member gaps in care. We will use a variety of tools to analyze claims and clinical data to identify providers with opportunities for improvement (e.g., a significant percentage of members that have not received an STI screening); members with

potential gaps in care (e.g., members who have not received STI screenings); and at risk populations that have not had STI screenings, such as pregnant members.

Monitoring the effectiveness of our outreach and paying incentives. We will monitor our outreach efforts and incentives to track the effectiveness of our program and, identify opportunities for improvement. We will pay incentives to providers by tracking adherence to STI screening protocols through analysis of relevant HEDIS measures (e.g., chlamydia), claims data, and diagnosis and procedure codes for STI screenings that do not have specific HEDIS measures.

Providing education and incentives to providers to conduct STI screenings. Based on our experience in Louisiana and other state Medicaid programs, we will provide additional compensation to providers to conduct STI screenings and educate their members about the importance of receiving these screenings through our OB incentive program described in Section Z. We will track provider STI screenings by analyzing HEDIS measures (chlamydia) and claims data and diagnosis and procedure codes. Incentives will include:

- Paying higher than Medicaid rates for each STI screening
- Bonuses for achieving HEDIS targets for Chlamydia screenings for the provider's members

We contract with school-based health centers (SBHCs) to perform STI screenings. We are already contracted with 95 percent of the SBHCs throughout the State and expect to be contracted with all SBHCs by the end of 2014. We will pay SBHCs to provide the screenings and pay higher than Medicaid rates for each screening.

We will conduct the following outreach and education to providers to make providers aware of the incentives available to provide STI screenings, how to receive the incentives and develop partnerships to increase the likelihood the members will receive STI screenings:

- Provider advocates will provide training on the importance of STI screenings, give providers educational materials for their members and ensure that providers are aware of STI screening incentives and what the provider needs to do to receive the incentives.
- Our maternal health coordinator will provide training to OBs on the importance of STI screening and ensure that providers are aware of STI screening incentives and what the provider needs to do to receive the incentives.
- Our provider claims educator will provide claims training (e.g., properly coding claims) and training about this program.
- Clinical practice consultants will:
  - Educate providers on the program and the importance of screening all members at the age of sexual activity.
  - Work with providers to conduct outreach to members (e.g., scheduling appointments with non-complaint members to receive their screenings).

In 2013, Bayou Health program CPCs conducted HEDIS training at 281 primary care provider locations and distributed 409 evidence-based quality performance guidelines toolkits developed by National Quality Management and Performance. Based upon the number of providers we impacted, we determined that we were able to influence the care of more than 131,900 members.

- Work with providers to develop other member outreach programs, such as cobranded letter campaigns and cobranded clinic days, to bring members in and get their screenings at that time.

- Information on our provider portal, *unitedhealthcareonline.com*, and in BayouCloud explain the importance of providing the screenings, the STI screening incentives and what the provider needs to do to receive the incentives.

Providing education and incentives to members to get their STI screenings. We will track member compliance with STI screenings using relevant HEDIS measures, claims data and diagnosis and procedure codes. We will provide a $20 gift card to adult members that see their PCP within the first 90 days of enrollment and to children ages 1 through 17 who see their PCP annually.

We will educate members about the importance of STI screenings and how to receive them through the following outreach:

- Provider advocates, CPCs and community health workers distribute educational materials through provider offices and community-based organizations.
- Community health workers and case managers provide education when working with members.
- Pregnant members in our Healthy First Steps program receive education about the importance of STI screening and how to receive screenings.
- Clinical practice consultants conduct outreach to members, in partnership with providers that have not received their STI screenings and help them make an appointment with the provider to get their screening.
- Deliver targeted mailings to members that have not received their screenings and who are at risk (e.g., members at the age of sexual activity) that explain the importance of receiving the screenings and how to obtain them.
- Through our member portal, *myuhc.com*, and our health4me mobile app that explain the importance of receiving the screenings and how to obtain them.

Building on our person-centered model of care for high-risk members. Case managers, CPCs and community health workers will conduct targeted outreach to high-risk members that have not received their STI screenings. They will explain the importance of receiving the screenings, help the member schedule an appointment with their provider to receive the screenings and monitor the member to ensure they go to the appointment and receive the screenings. For pregnant members, HFS case managers conduct this outreach.

We consistently seek opportunities to engage the communities we serve through partnerships with key leaders and organizations. Since the implementation of the Bayou Health program, our outreach team has engaged in and/or hosted more than 1,600 events reaching an estimated 615 thousand Louisianians, including more than 150 health screening events and health fairs, reaching approximately 43,000 Louisianians.

Partnering with community-based organization to provide member education and health screenings. Our community outreach team provides education and materials to community-based organizations to educate their constituents about STI detection and prevention, the importance of STI screenings and how to receive screenings. We partner with community-based organizations (e.g., faith-based organizations and SBHCs)

to participate in community events where we can provide education about STI screenings.

N.6 Describe your plan to address prematurity prevention and improved perinatal outcomes. The plan may include but not be limited to the following:

- Routine cervical length assessments for pregnant women;
- Provision of injectable or vaginal progesterone for every eligible pregnant woman with a history of pre-term labor or a short cervix found in the current pregnancy.
- Incentives for vaginal birth after cesarean (VBAC);
- Provider or patient incentives for post-partum visit provision within recommended guidelines of 21-56 days post-delivery;
- Incentives for use of long acting reversible contraceptives, which are to be provided to the member without prior authorization; and
- Interventions to reduce Cesarean section rates including but not limited to prior authorization for induction of labor prior to forty-one (41) weeks gestational age. (10 points)

According to the March of Dimes, 15 percent of Louisiana babies are born pre-term, the second highest rate in the nation. These babies are at a higher risk of developing health complications that can adversely affect vision, hearing, heart rate, blood health, immune systems and breathing. In an average week in Louisiana 1,205 babies are born, 184 babies are born preterm, 130 babies are low birth weight and nine babies die before reaching their first birthday.

In other states, such as Tennessee and Wisconsin, we have successfully piloted and implemented OB health homes to improve member outcomes by engaging members in earlier prenatal care. In Louisiana, we will engage with OBs; the American Congress of Obstetricians and Gynecologists; the Association of Women's Health, Obstetrics and Neonatal Nurses; and the Louisiana Academy of Family Physicians to share information we have gleaned from key stakeholders and collaborate to develop an OB health home solution that meets the needs of Louisianians.

In 2012, 40.2 percent of live births were cesarean deliveries and about one in 16 infants (6.5 percent of live births) were born to a woman receiving late or no prenatal care. Louisiana has one of the highest premature birth rates in the nation. In 2012, one in seven babies (15.3 percent of live births) was born premature in Louisiana. Among non-Hispanic blacks, nearly one in five (19.8 percent) babies was born premature.

Maternal mortality, perinatal mortality and neonatal mortality are typically associated with events occurring during pregnancy and delivery. Even if a high-risk pregnant woman delivers a viable infant, the complications of prematurity and low birth weight remain of great concern. The problems that preterm and low birth weight infants face are primarily related to the immaturity of their organ systems. Both preterm and low birth weight infants usually require care in a specialized nursery until the organ systems have developed adequately to sustain life without additional support. Depending on the level of prematurity or birth weight, this may take weeks or months and may ultimately result in life long health related and psychosocial issues.

Consideration of additional socioeconomic risks within the Medicaid-eligible population related to maternal and infant outcomes as well as the frequency of childbirth within this population support the need for an approach that coordinates processes, programs and resources to improve perinatal outcomes. The elements of UnitedHealthcare's approach include:

- ***Implementing programs designed specifically to identify and support pregnant members*** throughout their pregnancy, such as our Healthy First Steps maternity management program, Text4Baby text-messaging education program and Baby Blocks, our program that encourages and incentivizes pregnant women and new mothers to attend their prenatal, post-partum and well-baby appointments.
- ***Identifying and engaging high-risk pregnant members.*** Risk factors, such as hypertension, previous preterm delivery, diabetes, HIV, syphilis and sickle cell disease, will place members at the highest risk level. Through high-risk case management and through face-to-face interactions from case managers, community health workers and Alere OB nurses, we provide high-risk members with coordinated services and supports to manage their pregnancy and improve outcomes for the mother and child.
- ***Community engagement and community grants.*** We are engaging community-based organizations to reduce the high prevalence of pre-term delivery among young mothers in northeast Louisiana. Additionally, we are developing a $50,000 grant program for local organizations that can develop innovative ways to increase the likelihood that pregnant teens will experience healthy pregnancies.

For members with a history of spontaneous singleton preterm birth, Healthy First Steps case managers will coordinate with Alere to have OB nurses provide weekly injections of compounded 17P* or Makena® in the member's home to prevent reoccurrence of preterm birth.

During these visits, Alere OB nurses will provide member education related to preterm labor/pregnancy complications, ensure medication compliance by scheduling injections to meet the member's needs, and provide weekly reports to HFS case manager and the prescribing physician.

- ***Bayou Health Obstetrician (OB) Provider Incentive program*** aligns incentives for OBs to ensure our members receive needed prenatal and postpartum care, resulting in reduced hospitalizations, ER visits, low birth weights, pre-term deliveries and cesarean sections.

The following table presents the solutions we have implemented to prevent premature births and improve perinatal outcomes, such as HFS, or will implement, such as our Bayou Health OB Provider Incentive program. We have aligned the solutions to each of the requirements identified in RFP Question N.6 and discuss each solution in the sections following the table.

State Requirement	Solutions to Achieve the Requirement
Routine cervical length assessments for pregnant women	▪ We will encourage the completion of cervical length assessments through our Bayou Health OB Provider Incentive program and coordinate these assessments through Healthy First Steps. ▪ Through our provider profiling program, CPCs and provider advocates will work with providers that are struggling to provide this assessment by offering education, identifying barriers and identifying members with gaps in care. They will collaborate with providers to conduct outreach targeted to meet the needs of non-compliant members and bring these members into the OB's office to close gaps in care. ▪ Community health workers will support the efforts of CPCs and provider advocates by working with members to overcome barriers, such as transportation issues, member not knowing their PCP and member perception about cost.
Provide injectable or vaginal progesterone for every eligible pregnant woman with a history of pre-term labor or a short cervix found in the current pregnancy	▪ We will perform HRAs and analyze claims history to identify members with a history of pre-term labor or a short cervix. ▪ We will encourage the administration of prenatal progesterone for members at risk of pre-term birth through our Bayou Health OB Provider Incentive program. ▪ We will provide injectable progesterone, based upon a provider prescription, through our partnership with Alere. ▪ Through Healthy First Steps, we will educate members about the importance of receiving progesterone to reduce the risk of pre-term birth. ▪ Case managers will coordinate this service for high-risk members. ▪ Clinical practice consultants and provider advocates will work with providers to educate them about the availability of this service for their members. ▪ Through our provider profiling program, CPCs will conduct chart review audits to determine if the provider is appropriately prescribing this service for members at risk of pre-term birth.
Incentives for vaginal birth after cesarean (VBAC)	▪ We will perform HRAs and analyze claims history to identify members with a history of cesarean delivery. Member incentives are available to encourage completion of the HRA as outlined in our response to section Y. ▪ We will encourage the completion of the VBAC evaluation through our Bayou Health OB Provider Incentive program. ▪ Clinical practice consultants and provider advocates will educate providers about the incentives available to OBs for completing the OB assessment. ▪ Through HFS, we will educate members about the importance of receiving this assessment and HFS case managers will coordinate the assessment for high-risk members.

State Requirement	Solutions to Achieve the Requirement
Provider or patient incentives for post-partum visit provision within recommended guidelines of 21-56 days post-delivery	▪ We will encourage the completion of prenatal and post-partum visits through our Bayou Health OB Provider Incentive program. ▪ We will require post-partum visit encounter notation on the global visit claim for the global payment to be made; otherwise the payment will be reduced to the visit and delivery rates. We will provide this information in our *Provider Administrative Guide* and through OB education. ▪ HFS case managers will contact members to ensure the member goes to the post-partum visit. ▪ We will remind members of the need to attend this visit through Text4Baby. ▪ Clinical practice consultants and provider advocates will educate providers on properly coding claims indicating they have completed the post-partum visit. In the absence of claim, CPCs will conduct chart audits to determine if the provider has completed the post-partum visit. ▪ In addition to OB provider incentives, we will provide incentives to members to go to prenatal and post-partum visits through our Baby Blocks program.
Incentives for use of long acting reversible contraceptives, which are to be provided to the member without prior authorization	▪ We will encourage the use of long acting reversible contraceptives for interested members through our Bayou Health OB Provider Incentive program. ▪ Clinical practice consultants and provider advocates will educate providers about the use of long acting reversible contraceptives and the availability of this service to members without prior authorization. ▪ Healthy First Steps case managers will educate members at all risk levels regarding appropriate contraceptive choices, based upon recommendations of the American College of Obstetricians and Gynecologists. ▪ We will provide this service to members without prior authorization.
Interventions to reduce Cesarean section rates including but not limited to prior authorization for induction of labor prior to 41 weeks gestational age.	▪ In cooperation with DHH's efforts to deter preterm delivery, we require pre-authorization of labor induction prior to 41 weeks. ▪ We require proof of medical necessity for cesarean sections and will issue a post service denial if the provider cannot demonstrate medical necessity. ▪ Through Healthy First Steps, CPCs and provider advocates, we provide education to the member and OB about the risk of inductions that are not medically indicated.

In 2013, we enrolled 1,265 members in HFS. Through our efforts to identify and enroll members in HFS, we have seen a 12 percent increase in monthly HFS member enrollments through the first two quarters of 2014.

Addressing Prematurity Prevention and Improved Perinatal Outcomes

Implemented in Louisiana in 2012, our Healthy First Steps maternity management program promotes healthy birth outcomes for pregnant members, especially those with high-risk pregnancies. HFS seeks to identify all pregnant members early in their pregnancy and assess and risk stratify

those members, enabling prospective outreach and education to the appropriate population.

Healthy First Steps recognizes that the basic premise of a successful program is proactive health management to improve the member's clinical outcomes and quality of life. The scope of the Healthy First Steps program includes activities that support recommended standards of care and key treatment elements as described in the evidence-based practice guidelines from the American College of Obstetricians and Gynecologists, Centers for Disease Control (CDC) Recommendations for HIV Screening of Pregnant Women and *MCG*.

In 2013, we enhanced our engagement of newly-identified pregnant members by transferring the member directly to a HFS RN upon initial contact if an HFS RN is available. If an HFS RN is not available, we schedule a formal appointment with an HFS RN through *MyHealthDirect*. Follow-up appointments with the HFS RN can also be scheduled through *MyHealthDirect* for the member's convenience.

In 2014, we implemented additional features of *MyHealthDirect,* such as allowing the expectant mother to choose to receive a reminder email, voice or text the day before their scheduled appointment with an HFS RN.

Healthy First Steps activities enhance the practitioner-patient relationship and the member's compliance with their plan of care. In addition, Healthy First Steps emphasizes activities and treatments that can help prevent pregnancy related complications, using cost-effective and patient-involvement strategies.

Healthy First Steps care management services help support increased member compliance through patient education related to normal pregnancy, the recognition and reporting of signs and symptoms of potential complications, lifestyle and preventive health counseling in conjunction with increased awareness of community resources.

Healthy First Steps enhances our person-centered model of care by enrolling high-risk pregnant members in a targeted program that addresses member needs within the continuum, including education and counseling, targeted case management and collaboration with providers and community resources to effectively support an improved pregnancy outcome. High-risk case management engages members with OB-experienced nurse case managers who monitor and coordinate care for those members at greatest risk for pre-term labor, pre-term delivery or other adverse perinatal outcomes.

Managing Post-Partum Depression

In spring 2013, our Bayou Health member "Delilah" gave birth to her first child by cesarean section. Delilah wants to be a good mother and enrolled in Healthy First Steps prior to delivery. Delilah has been feeling isolated and overwhelmed since her baby's birth. Because her early attempts at breast feeding did not go well, she tried a bottle feeding formula. When the baby began spitting up the formula, her pediatrician suggested a gentler formula, but that seemed to make the problem even worse. Delilah grew increasingly frustrated and was beginning to question her abilities as a mom. In addition, she did not know about the resources available to help her.

Because Delilah enrolled in Healthy First Steps, she knew her Healthy First Steps nurse and contacted her to express how upset and overwhelmed she was feeling. As a result of the discussion, her nurse immediately connected Delilah with a social worker and counselor. She also helped Delilah schedule an earlier appointment with her OB/GYN. A few days later, the nurse followed up with Delilah to see how she was doing. After meeting with her OB/GYN, Delilah received a prescription for an antidepressant to help with her postpartum depression. The meetings with the counselor and social worker helped Delilah start to feel calmer and the nurse reassured her that as long as her baby was eating, she should not worry.

Thanks in part to the help and support from the Healthy First Steps nurse, OB/GYN, counselor and social worker, Delilah was able to access the resources that helped her deal with her postpartum depression. Delilah appreciates all the benefits Healthy First Steps provided her both during and after her pregnancy.

Identifying Pregnant Members and Engaging them in HFS Care/Case Management

We proactively identify pregnant members through the State's 834 enrollment file; lab, physician and pharmacy claims analysis through Impact Pro; the member welcome call and application of the HRA; provider referrals; obstetrician completion of the OB risk assessment form at a first pregnancy visit; member self-referral; or referral by a UnitedHealthcare employee, such as an member services representative.

In 2013, the Healthy First Steps utilization team developed a process to refer an expectant mother admitted to a facility to Healthy First Steps permitting earlier outreach and planning, such as conducting a face-to-face visit with a Healthy First Steps case manager or community health worker and engaging the member in case management, as indicated by the member's need. Previously notification occurred at hospital discharge.

Once identified, we implement a fast-track process for all new pregnant members that refers the member to a Healthy First Steps RN where they will receive additional screening to identify pregnancy risk factors. Healthy First Steps stratifies the member into three levels of risk based on the Healthy First Steps OB clinical assessment, which includes a comprehensive review of obstetrical and medical history and a psychosocial assessment. Risk factors, such as hypertension, risk of pre-term birth, diabetes, HIV, syphilis and sickle cell disease, will place members at the highest risk level.

Healthy First Steps Supports for all Pregnant Members

For all pregnant members, we provide Healthy First Steps care management services that support increased member compliance with behaviors that lead to healthy outcomes for the mother and baby, including education related to normal pregnancy, recognition and reporting of signs and symptoms of potential complications, lifestyle and preventive health counseling, and increased awareness of community resources. The supports include:

- Educating members about the importance of receiving routine health screenings, such as HIV, syphilis and chlamydia, helping the member schedule an appointment with their provider to receive the screenings and monitoring the member to ensure they go to the appointment and receive the screenings.
- Educating members on the importance of scheduling postpartum and well-baby visits.
- Educating members about interpregnancy care, especially contraceptive choices, including long acting reversible contraceptives, based upon recommendations of the American College of Obstetricians and Gynecologists.
- Helping members to access community resources (e.g., Women, Infants and Children).
- Providing additional supports, such as community health workers, to help members overcome barriers to receiving these prenatal and postpartum services (e.g., transportation, not knowing their PCP).
- Monitoring completion of the postpartum exam and encourage scheduling of well-baby checkup appointments.
- Performing a post-partum assessment of the member's transition needs after pregnancy, including identifying health risks, post-partum depression and ongoing care or case management engagement needs. If we determine high-risk members continue to need case management services, we engage the member with a case manager or an ACC practice to manage their care.
- Provide telephonic outreach at a frequency based upon the member's needs. Calls may occur as frequently as daily but will occur no less often than every four weeks based on clinical need. These calls educate and reinforce member behaviors for pregnancy management, preventive health behaviors, recognition and reporting of potential complications, provider visit compliance, help obtaining prescription refills or making medical appointments.

Our HFS program has helped to reduce Healthy First Steps authorized NICU admissions per 1,000 and NICU days per 1,000 in Louisiana. For example:

- NICU admissions per 1,000 in Q1 2013 compared to Q1 2014 were reduced by 4.3 percent
- NICU admissions per 1,000 for the 12 months of 2013 compared to Q1 2014 were reduced by 5.6 percent.
- NICU days per 1,000 for first two months of 2014 compared to the 2013 average were reduced by 36 percent.

HFS Supports for High-Risk Pregnant Members

For members' identified as high-risk, we assign the member to an HFS OB-experienced nurse case manager. Once enrolled in the HFS program, HFS case managers:

- Develop a plan of care tailored to meet the member's unique needs with interventions targeted to improve maternal and infant outcomes. Pregnancy plan of care interventions focus on member education (e.g., signs and symptoms of complications, breast-feeding, nutrition and smoking cessation) and provide ongoing reminders and support on the importance of regular obstetrician visits.
- Communicate with the member's OB provider to coordinate services, monitor the member's progress and adjust the plan of care, if needed.

Through HFS high-risk case management and through face-to-face interactions from HFS case managers, community health workers and Alere OB nurses, we provide high-risk members with coordinated services and supports to manage their pregnancy and improve outcomes for the mother and child.

- Coordinate referrals for additional services, such as social worker intervention, specialty providers or community partners.
- For members with a history of spontaneous singleton preterm birth, coordinate with Alere to provide weekly injections, as needed, in the member's home to prevent reoccurrence of preterm birth. Alere services can also be used to manage diabetes and insulin, prevent nausea/vomiting and manage blood coagulation disorders.
- For members identified with substance abuse or mental health issues, coordinate with a behavioral health case manager to ensure the member has access to needed behavioral health assessments and services.

Partnering with Alere to Reduce the Incidence of Pre-Term Birth

The percentage of low weight Medicaid births is trending downward among our Louisiana members enrolled in Healthy First Steps. Through Q1 2014, the average low birth weight rate dropped to 9.3 percent compared to the 2013 average of 9.6 percent.

For members with a history of spontaneous singleton preterm birth or identified as high risk for pre-term birth, Healthy First Steps case managers will coordinate with Alere to provide weekly injections (via Z-track) of compounded 17P or Makena® in the member's home with a provider's prescription. During the visit to administer the injection, the Alere OB nurse will provide member education related to preterm labor/pregnancy complications, ensure medication compliance by scheduling injections to meet the member's needs and provide weekly reports to Healthy First Steps case manager and the prescribing physician. Clinical practice consultants and provider advocates will educate providers about our partnership with Alere and the services available to high-risk pregnant members. They will give providers educational materials about the program and preterm labor/pregnancy complications.

Educating a Teenage Member about her Pregnancy

Kelsey is a pregnant teenager. Because this is her first pregnancy, she is unaware of what changes to expect during each trimester. Kelsey and the father of the baby are no longer together and she struggles with depression due to the breakup. She knows her depression is affecting both her and her unborn baby, so she wants to connect with a therapist and undergo counseling.

A Healthy First Steps nurse called Kelsey to educate her about pregnancy and answer any questions. Kelsey and the nurse discussed Braxton Hicks contractions, breast-feeding, drinking plenty of water, eating a healthy diet and taking prenatal vitamins. The nurse educated Kelsey about normal symptoms of pregnancy, such as nausea, fatigue, breast tenderness and swollen ankles. The nurse also reviewed signs and symptoms of preterm labor, miscarriage and pregnancy-induced hypertension.

The nurse also assessed Kelsey for gaps in care. Kelsey reported she was suffering from back pain, so the nurse provided tips for treating her pain, such as warm baths, light massage, low-heeled supportive shoes and Tylenol, as needed. When the nurse learned Kelsey struggled with depression over her breakup with the baby's father, the nurse referred Kelsey to a social worker for assistance connecting Kelsey with appropriate providers.

Thanks to the help and encouragement of the HFS nurse, Kelsey received advice, support and a comprehensive education about her pregnancy. She is working hard in therapy and starting to feel better about her future.

Additional Supports for Pregnant Members

Through Text4Baby and Baby Blocks, we provide member education and additional supports to pregnant members and new mothers that provide critical information and service reminders at key milestones throughout pregnancy and after the baby is born. Additionally, we provide rewards to members who attend prenatal, postpartum and well-baby appointments.

Member Education

We believe access to education is the crucial element required to change pregnancy and child care health outcomes in our communities. We provide expectant mothers with critical information related to prenatal care, nutrition, prematurity prevention and parenting through our innovative programs and community outreach, such as:

- Healthy First Steps provides members with additional support and education throughout their pregnancy.
- Baby Blocks reminds expectant mothers about impending prenatal or postpartum appointments and provides incentives for participation.
- Text4Baby provides expectant mothers with informative and educational texts about pregnancy and child care.
- Educational initiatives in schools and health fairs educate teenagers about the maternal-fetal risks of young motherhood and premature births.

The Nurse Family Partnership (NFP) is an evidence-based home visitation model for Medicaid-eligible first-time mothers and their families that provides nurse visits that begin in the first or second trimester of pregnancy and continue until the child turns two years old. Nurses provide education, support and guidance to help women have a healthy pregnancy and care for their baby. We collaborate with NFP to receive referrals for pregnant women who might benefit from Healthy First Steps and to provide referrals to NFP so they can deliver support and services to pregnant women.

- Community outreach, such as our NE Louisiana OB Initiative, works with community-based organizations to develop initiatives to provide outreach and educate teenagers on the complications of teen pregnancy and increase the likelihood that pregnant teens will experience healthy pregnancies.
- As a value added benefit, we will provide an infant care book ("What to Expect When Expecting") to all pregnant members. This book is an additional resource for our pregnant members and new parents and provides important information about baby care and healthy pregnancies; thereby increasing the knowledge of pregnant mothers and parents and promoting the safety, health and well-being of the babies and mothers.

To improve prenatal and neonatal outcomes, we have collaborated with the Louisiana Strong Start maternal-child care initiative. Through Strong Start, Louisiana implements the Centering Pregnancy model of care as defined by the Centering Healthcare Institute. In this model of care, pregnant women from a common geographic area receive education and mentoring in groups, while each separately receives a private exam during the session. This method of delivery of care supports healthier outcomes while providing the much needed social support to many future mothers. We have been and will continue to be strong supporters of this initiative.

Text4Baby

Text4Baby is a free service for pregnant women and new parents that delivers tips and support via text messages throughout pregnancy and the baby's first year. Topics include exercise, fitness and nutrition; labor and delivery; car seat safety; and breast feeding. Women who sign up for the program receive texts two to three times a week. Messages are customized to specific milestones, such as a woman's due date or the baby's date of birth. We also deliver broadcast messages to our Louisiana members regarding Hurricane preparedness, access to local resources and access to additional UnitedHealthcare member resources, such as NurseLine.

Baby Blocks

Baby Blocks encourages pregnant women and new mothers to attend their prenatal, post-partum and well-baby appointments. It uses online/mobile tools to remind and encourage pregnant members to keep their wellness appointments and is offered to all newly-identified pregnant members. The goals of the program are to:

- Increase HEDIS results for prenatal, post-partum and well-child visit compliance
- Improve the retention of new mothers and infants by offering incentives (nominal gifts) for prenatal, post- partum and well-child visits
- Decrease medical costs through improved member engagement in wellness behaviors
- Increase personal responsibility in our members who are mothers to be or new mothers.

We make pregnant members aware of the program through mailings, brochures delivered through OBs and our HFS program. Once they enroll and provide their demographic information and due date, members receive messages that are relevant to them and

their pregnancy. The program uses interactive tools, delivered online or through a smartphone, to remind and encourage pregnant members to keep their wellness appointments.

Members are rewarded for hitting key milestones, such as their 6-month prenatal visit, 8-month prenatal visit, post-partum visit, their baby's 6-month wellness visit and completion of their baby's blood lead screening. At each milestone, the new mom can select a reward. Key milestones and rewards are presented in the following table.

Milestone	Option One	Option Two
Baby blocks enrollment	Diaper bag	$20 gift card for the purchase of maternity or baby items
24-week prenatal	Nursing cover	Teething rattle
32-week prenatal	First aid kit	Tabletop toy
Birth	Digital thermometer	Bath thermometers
Postpartum visit	Sorting blocks	$20 gift card for the purchase of maternity or baby items
6-month well child	Feeding set	Dental care set
Lead screening	Childproofing set	Board book
15-month well child	Shower/bath accessories	Soft puzzle

NE Louisiana OB Initiative

UnitedHealthcare works with hundreds of community-based organizations across the country to build healthier communities. We understand the importance of their work and the funding challenges they face to serve as many individuals as efficiently and compassionately as possible.

We believe that developing partnerships with faith-based and community-based organizations is an effective way to engage pregnant teen members and provide them the right education and supports they need to experience healthy pregnancies.

On June 13, 2014, we hosted a meeting with 22 community and faith-based organizations, nonprofits and other partners that work on the issue of teen pregnancy to share ideas on improving birth outcomes in the state, particularly in northeast Louisiana, where rates of pre-term birth are highest.

We followed this session with a partner survey to gather additional partner input. Key themes from the brainstorming session and follow-up survey include:

- ***Barriers to improving birth outcomes:*** Poverty, lack of access to care due to geography, transportation, lack of specialty care (mental health, substance abuse, domestic violence), difficulty connecting to young women, family/caregiver attitudes and funding for the most effective programs.
- ***Effective strategies to improve birth outcomes:*** Increase education and improve access to and the quality of health care, including in schools

We will use the insights from the conversations with partners, providers and young women to develop a $50,000 grant opportunity for community-based organizations in northeastern Louisiana that can develop innovative ways to outreach and educate teenagers on the complications of teen pregnancy and increase the likelihood that pregnant teens will experience healthy pregnancies.

- ***Effective program characteristics to improve birth outcomes:*** Strengthen relationships between schools, health care and faith-based organizations, establish personal relationships with at-risk youth and provide incentives for teen participation.

We are continuing this brainstorming session, in partnership with Children's Coalition of NELA in Monroe, September 26, 2014. The session will include young women who are currently pregnant or who have recently given birth. The purpose is to understand the perspectives, hopes, dreams and challenges of these members.

We will use the insights from the conversations with partners, providers and young women to develop up to $50,000 in grant opportunities for community-based organizations in northeastern Louisiana that can develop innovative ways to outreach and educate teenagers on the complications of teen pregnancy and increase the likelihood that pregnant teens will experience healthy pregnancies.

Our prematurity birth rate decreased in 2013 from 12 percent in Q1 to 10.5 percent in Q4. Average gestational age increased in 2013 from 38.0 weeks in Q1 to 38.2 weeks in Q4.

We have recently developed OB health homes in Tennessee and Wisconsin. Although these programs are too new to provide data showing improved outcomes, they are showing promise and we are receiving positive feedback. We will use the information gleaned from our community engagement as well as lessons learned from Tennessee and Wisconsin to engage key Louisiana stakeholders, such as OBs; the American Congress of Obstetricians and Gynecologists; the Association of Women's Health, Obstetrics and Neonatal Nurses; and the Louisiana Academy of Family Physicians, to identify opportunities to develop OB health homes.

Bayou Health OB Provider Incentive Program

Our Bayou Health OB Provider Incentive program will align incentives to OBs to ensure our members receive needed prenatal and post natal care and reduce cesarean sections. Improved access to OB services results in improved pregnancy outcomes for both the mother and the baby, including reduced hospitalizations, ER visits, low birth weights, pre-term deliveries and cesarean sections. We have provided details of the OB provider incentives in Section Z.

In Arizona, we implemented an OB provider incentive program designed to improve alignment of reimbursement with improvements in health care quality, access, efficiency, and assignment of pregnant moms to high quality care. Through this program, OBs who demonstrated such improvements received higher reimbursement than lower performing OBs. Additional incentive payments enabled OBs to fund organized, sustained outreach efforts to get our members needed prenatal and post natal care. As a result of this program, we have experienced reduced hospitalizations, ER visits, low birth weights and pre-term deliveries.

Program goals include:

- Increase utilization of primary obstetrical services
- Increase utilization of pre and post-partum care
- Improve quality of health care outcomes
- Increase utilization of preventive health services, such as STI screenings
- Improve maternal child health outcomes (e.g., decrease low birth weight and pre-term pregnancies)
- Reduce ER utilization for high-risk pregnancies
- Improved access to and utilization of interpregnancy services, such as the use of long-acting reversible contraceptives

- Early identification of high-risk pregnancies (e.g., pre-term labor, hypertension, diabetes) and initiation of interventions, such as 17P to reduce the occurrence of pre-term birth

To identify providers for outreach and monitor the effectiveness of the program, we will analyze quality and utilization measures from:

- Claims data using SMART (e.g., normal deliveries, C-Sections, prenatal visits and post-partum visits)
- Claims data from Impact Pro to identify care opportunities for pregnant members (e.g., missed health screenings)
- Data from Healthy First Steps (e.g., OB risk assessment completion, low birth weight, pre-term deliveries and post-partum visits)
- Relevant HEDIS measures (e.g., W15-Well Child Visits in the First 15 Months of Life, Chlamydia Screenings)

Through CPCs, provider contracting associates (staff that execute provider contracts) and provider advocates, we will conduct outreach to OBs to make them aware of these incentive programs and the importance of providing these services to our pregnant members. Through our provider profiling program, CPCs and provider advocates will work with providers that do not meet the quality benchmark related to prenatal and postpartum care, to identify, using the data analyses described below, areas of improvement and develop ways to collaboratively conduct outreach targeted to meet the needs of non-compliant members and bring these members into the OB's office to close gaps in care.

Clinical practice consultants introduced the State-sponsored LaHart program to OB practices statewide. Our maternal health coordinator supported this effort by educating OB providers about the program.

We will provide incentives to OBs for:

- Completing the OB risk assessment form (OBRAF), including the vaginal birth after cesarean (VBAC) evaluation and faxing it to Healthy First Steps - $10 per assessment completed.
- Conducting the prenatal visit and properly coding the claim allowing us to track compliance with this visit. Access to the full case rate is available only to OBs who provide these services. Otherwise, OBs will be paid the fee-for-service (FFS) rate for the delivery only.
- Conducting the postpartum visit and properly coding the claim allowing us to track compliance with this visit. Access to the full case rate is available only to OBs who provide these services. Otherwise, OBs will be paid the FFS rate for the delivery only.
- Conducting the cervical length assessment for pregnant women - $10 per assessment completed.
- The use of long acting reversible contraceptives - $10 additional reimbursement above the Medicaid rate per procedure completed.
- Application of antenatal progesterone - $20 per in office application and/or script filled for home application.

Our maternal health coordinator engages to support State pregnancy initiatives and directs education target to specific OB providers.

- Conducting STI screenings including chlamydia, HIV, syphilis and gonorrhea - $10 per screening (limited to one incentive per visit)

We are developing a performance improvement project, presented in Section U.5, which focuses on improving rates of the application of antenatal progesterone through reimbursement reform, provider education and dissemination of antenatal progesterone clinical practice guidelines.

While we will incentivize OBs to complete the OB risk assessment, we will educate OBs that do not wish to complete this assessment that they can refer a pregnant member to us. Our HFS team will complete the HFS OB clinical assessment and, if the member is high-risk, engage the member in case management. This alternative to the OB risk assessment reduces the administrative burden on the OB, while ensuring the member is assessed and has all the tools and support she needs to have a healthy pregnancy and delivery. We document this process for providers in the *Provider Administrative Guide*.

OB Outreach to Achieve Healthy Outcomes for Pregnant Members and Babies

In late 2013, we implemented an outreach campaign to promote collaboration among the case manager, member and OB to achieve healthy outcomes for pregnant members and babies. We analyzed claims data to target OBs for outreach and targeted OBs with 25 or more deliveries. We eventually expanded our outreach to every OB that had submitted a claim to us.

Through Q2 2014, our maternal child health/EPSDT coordinator, Beverly Shields, conducted 178 phone calls and 175 onsite visits to OBs through the State and neighboring states, if needed, to educate OBs about:

- Completing and faxing the OB risk assessment form
- Compounded 17P* or Makena® is a covered benefit for members at high risk of pre-term birth
- Importance of cervical cancer and Chlamydia screenings

At the end of each visit, Ms. Shields provided the OB with:

- Healthy First Steps brochures to distribute to members
- A copy of the OB risk assessment form
- A HEDIS quick reference code guide
- Contact information for Ms. Shields

As a result of our efforts, OBs have submitted nearly twice as many OBRAFs (658 versus 352) in the first two quarters of 2014 compared to all of 2013.This is an annualized increase of 274 percent. The rates for Chlamydia screening and cervical cancer screening have also increased by 8.79 percent and 9.46 percent respectively.

N.7 Explain how you will Identify and address underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives and appropriate pain management approaches in patients with sickle cell disease. (5 points)

We recognize that underutilization of services can result in gaps in care leading to poor outcomes, including increased ER utilization, increased hospital admissions and readmissions, poor management of chronic conditions, and delayed identification of and intervention in diseases. To address underutilization of services, through our person-centered model of care we identify members who have gaps in care, including underutilization, and implement multiple strategies to engage members and providers to close these gaps. Some specific areas of focus are underutilization of OB/GYNs, disease screenings and preventive care, pain management in patients with sickle cell disease, use of long-acting reversible contraceptives and appropriate use of primary care.

We address the underutilization of services using the following methods:

- Identifying members with gaps in care (e.g., members who have not received screenings) and providers with opportunities for improvement (e.g., a significant percentage of members that have not received screenings).
- Coordinating member care with a level of care management that meets their needs (e.g., care coordination or case management)
- Coordinating and managing health care services for high-risk members through case managers, community health workers, providers and ACC practices
- Incentivizing providers to provide services that are being underutilized (e.g., health screenings, STI screenings, screenings in pregnant women).
- Educating members about the services available to them, the importance of receiving these services and how to obtain them.
- Promoting the relationship between the member and their PCP or ACC practice and encouraging the member to visit their PCP or ACC practice for needed services
- Educating providers about the importance of providing these services, the incentives available to provide these services and how to receive the incentives.
- Coordinating with providers to develop campaigns to reach members who need preventive services and bringing members in to the provider's office to receive them.
- Implementing programs to address the needs of members with specific needs, such as pregnant members and members with sickle cell disease
- Providing additional supports, such as community health workers, to help members overcome barriers to receiving these services (e.g., transportation, not knowing their PCP).

In the following sections, we will discuss the role of the PCP or ACC practice in providing services to members and present our approach to improving the rates of STI screening among pregnant members through their OBs and our approach to providing pain management support to members with SCD.

Building the Member/PCP Relationship

We promote the member relationship with their PCP through the coordinated efforts of care managers, community health workers and CPCs. For example, CPCs promote this relationship by developing co-branded clinic days with providers to provide needed screenings and care to members that have not received screenings or other health care services. It is through the PCP that members receive coordinated health care services, including preventive services, such as cancer screenings, diabetic screenings and STI screenings.

We contract with qualifying ACC practices to provide care coordination and health interventions. One of our focus points with ACCs is managing high-risk members. We promote this relationship by ensuring these members are seen every 90 days to have care gaps addressed and through community nurses who are assigned to specific ACC practices and collaborate with ACC practice case managers to deliver member care. The nurses review members' risk factors, preventive tests, services and physician-recommended interventions and follow up with external referrals to confirm the member is following those recommendations. Additionally, community nurses ensure that all population health interventions occur by leveraging themselves and

practice clinical staff, including face-to-face support, to promote healthy behavior changes (e.g., smoking cessation and weight loss).

Ensuring Pregnant Members Receive Appropriate Screenings

We believe that providing prenatal and postpartum care, STI screenings and interpregnancy counseling and care should be a standard part of an OB's practice and we will encourage the use of these services with members and OBs by:

- Identifying pregnant members, providers with opportunities for improvement (e.g., a significant percentage of pregnant members that have not received screenings) and pregnant members with potential gaps in care.
- Incentivizing providers to provide screenings (e.g., HIV, chlamydia and syphilis) in pregnant women and, through our Bayou Health OB Incentive program, outlined in our response to question Z, incentivize OBs to encourage the use of long-acting reversible contraceptives for interpregnancy care.
- Educating members about the services available to them, the importance of receiving these services and how to obtain them
- Educating OBs about the importance of providing preventive services, the incentives available to provide these services and how to receive the incentives.
- Coordinating with OBs to develop campaigns to reach members who need these services and bring them in to the OB's office to receive them.
- Providing additional supports, such as community health workers, for members in case management to help members overcome barriers to receiving these services.

Identifying Underutilization of Services in Pregnant Members

We proactively identify pregnant members through the State's 834 enrollment file; lab, physician and pharmacy claims analysis; the member welcome call and application of the HRA; provider referrals; obstetrician completion of the OB risk assessment form at a first pregnancy visit; member self-referral; or referral by a UnitedHealthcare employee, such as an member service representative.

We detect underutilization of HIV, chlamydia and syphilis screening and the use of long acting reversible contraceptives using various tools, such as Impact Pro, to analyze claims and lab data and diagnosis and procedure codes to identify women that are underutilizing these services.

Helping Pregnant Members Receive Screenings

Once a pregnant member has been identified, we implement a pregnancy fast-track process for all new pregnant members that refers the member to Healthy First Steps where they will receive additional screening to identify pregnancy risk factors. Healthy First Steps stratifies the member into three levels of risk based upon the Healthy First Steps OB clinical assessment, which includes a comprehensive review of obstetrical and medical history and a psychosocial assessment.

Healthy First Steps case managers will educate members at all risk levels about the importance of receiving these screenings. For members' identified as high risk through Healthy First Steps screening, we assign the member to a Healthy First Steps OB-experienced nurse case manager who will:

- Educate the member about the importance of receiving routine health screenings, including screenings for STIs.
- Help the member schedule an appointment with their provider to receive the screenings.
- Coordinate with community health workers to help members overcome barriers to receiving these services
- Monitor the member to ensure they go to the appointment and receive the screenings.

As discussed in our response to Section Z, we will provide additional compensation to OBs to conduct these screenings and to educate their members about the importance of receiving these screenings. We will track provider HIV, chlamydia, gonorrhea and syphilis screenings by analyzing claims data and diagnosis and procedure codes. Incentives will include:

- Paying higher than Medicaid rates for STI screenings
- Bonuses for achieving HEDIS targets for Chlamydia screenings for the provider's members

Additionally, we will work with OBs, as discussed below, to educate them about these screenings and develop campaigns to provide these screenings to pregnant members.

Helping Members Receive Long Acting Reversible Contraceptives

Healthy First Steps case managers will educate members at all risk levels regarding appropriate contraceptive choices for interpregnancy care, based upon recommendations of the American College of Obstetricians and Gynecologists. We will provide this service to members without prior authorization. As described in our response to RFP Question N.6, we will encourage the use of long-acting reversible contraceptives through our Bayou Health OB Incentive program.

Additionally, we will work with OBs, as discussed below, to educate them about the use of long acting reversible contraceptives and develop campaigns to encourage the use of long acting reversible contraceptives among members that are eligible to receive the service.

Educating OBs about Screening Services and Incentivizing OBs to Deliver Them

In 2013, Bayou Health program CPCs conducted HEDIS training at 281 primary care provider locations and distributed 409 evidence-based quality performance guidelines toolkits developed by National Quality Management and Performance. Based upon the number of providers we impacted, we determined that we were able to influence the care of more than 131,900 members.

We have adopted the American Congress of Obstetricians and Gynecologists' (ACOG's) evidence-based guidelines for HIV, chlamydia and syphilis screenings and the use of long-acting reversible contraceptives.

We foster clinician adherence to these guidelines by giving providers convenient access to them via our secure provider portal, *unitedhealthcareonline.com* on BayouCloud, or paper copy upon request. We inform providers of the availability of the guidelines in *Practice Matters*, the provider newsletter and *Provider Administrative Guide*.

We will conduct outreach to OBs to educate them about the guidelines, the importance of providing these services, the incentives available to provide HIV, chlamydia, gonorrhea and syphilis screenings in pregnant women and encourage the use of long acting reversible contraceptives, how to receive the incentives and develop partnerships to increase the likelihood

the members will receive screenings and contraceptive services. Provider advocates and CPCs will:

- Provide training on the relevant evidence-based guidelines for HIV, chlamydia, gonorrhea and syphilis screenings and the use of long-acting reversible contraceptives
- Provide training on the importance of HIV, chlamydia and syphilis screening in pregnant women
- Give OBs educational materials that they can share with their members
- Ensure that providers are aware of HIV, chlamydia, gonorrhea and syphilis screening incentives and what they need to do to receive the incentives.
- Educate OBs about the use of long acting reversible contraceptives, the incentives available to provide this service and the availability of this service to members without prior authorization.
- Work with OBs to conduct outreach to members (e.g., scheduling appointments with non-complaint members to receive these services).
- Work with OBs to develop other member outreach programs, such as cobranded letter campaigns and cobranded clinic days, to bring members in to receive these services.

Developing Campaigns with OBs to Improve Utilization of Screening Services

Based on the experience we gained through our chlamydia screening campaign and based on the elements of our approach to improve STI screening rates described in our response to Question N.5, we will engage OBs that are struggling to provide these services to our pregnant members. These elements include:

- Identify and target outreach to OBs with a significant percentage of pregnant members that have not completed an HIV, chlamydia, gonorrhea or syphilis screening.
- Target OBs with members that are eligible to receive long acting reversible contraceptives, but are not receiving them.
- Assign a CPC to engage the OB and identify and overcome barriers to care, such as CPC training on in office screening techniques or proper coding of claims.
- If the OB is amenable and has the capability to provide the services, the CPC will engage our quality outreach coordinator to conduct member outreach to educate members about these services and help members make appointments with their OB.

Pain Management Approaches in Patients with Sickle Cell Disease

We help members with SCD manage their pain through our sickle cell program, which enhances our person-centered, integrated model of care and is described in our response to RFP question N.4. Through our sickle cell program, we:

- Identify members with SCD that require pain management interventions and are at high risk of experiencing recurring pain crises.
- Engage high-risk members in case management through collaboration between a member's PCP and a case manager with expertise in managing patients with SCD or enrollment in an ACC practice with SCD expertise. For ACC practices without this expertise, our SCD case manager will partner with the ACC practice to manage the member's care.

- Develop an effective, individualized plan of care to reduce pain and manage symptoms, including short- and long-term goals.
- As part of plan of care development, ensure that the member has a pain management plan. The pain management plan allows the member to manage their daily pain levels so they are not visiting the ER or admitting themselves into the hospital.
- Coach members to have the confidence to be "self-advocates" so they work with their provider to get needed services to manage their pain.

In addition, we monitor this population to ensure pain medications are properly prescribed and used by members. One way we monitor the appropriate use of pain medications is through our pharmacy prospective and retrospective drug utilization review programs, which ensure pain medication are properly prescribed and identifies pain medication misuse. If we detect misuse, we can initiate mechanisms to ensure appropriate use through programs, such as our pharmacy lock-in program, which limits a member misusing pain medications to one pharmacy, one PCP or both.

Developing a Pain Management Plan

Our SCD case manager or ACC practice case manager will perform a pain management assessment on the member to understand their short term (daily) and long-term (monthly) pain levels and current pain remedies and preventive measures (e.g., oral fluids, analgesics and therapies) the member is using to manage pain. Based on the assessment, CDC and NIH guidelines, and checklist tools, we will identify gaps in care and coach the member to discuss preventive measures and pain remedies with their provider. If the provider is not willing (or able) to work with the member, we will perform a medical director peer-to-peer consultation with the provider to ensure that the provider helps the member manage their pain, without having to visit the ER. If the member is not complying with their pain management plan, we provide additional assistance to help the member manage their pain, such as working with the member's family to ensure the member is engaging in behaviors that help them manage their pain. Members that are stratified as low risk will not fall under the pain management process.

Pain management in sickle cell members who may be pregnant is a delicate balance best coordinated with a specialist as the routine treatment may include opioids. The SCD case manager and the HFS case manager (pregnant members with SCD are considered high risk and will be enrolled in HFS case management) will collaborate to provide member education on the need for supervised specialist care to minimize the effects on the fetus and ensure that providers are delivering evidenced-based care. Additionally, we will refer the member to a behavioral health case manager to co-manage their care.

N.8 Explain how you will reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than seven years of age. (5 points)

Health providers, school officials and parents have raised concerns about the accuracy and appropriateness of attention-deficit hyperactivity disorder (ADHD) diagnoses as well as the pharmacology prescribing practices

In the event an ADHD medication is prescribed for a child under the age of five and not prescribed by a specialist, the prescription will be reviewed by our psychiatrist to determine if the child:

- Has a diagnosis of ADHD
- Is unresponsive to, or has had an inadequate response to parent- and/or teacher-administered behavioral therapy
- Is experiencing moderate-severe continuing disturbance in function despite behavioral therapy

associated with the diagnosis. It is well established that ADHD frequently is comorbid with other psychiatric disorders (Pliszka et al., 1999) and requires intensive coordination between care providers, home settings and school. Studies have shown that 54 percent to 84 percent of children and adolescents with ADHD may meet criteria for oppositional defiant disorder (ODD) and a significant portion of these individuals will develop conduct disorder (Barkley, 2005; Faraone et al., 1997).

Given this, we believe there is opportunity to improve coordination, treatment and prescribing practices by:

- Adopting best practice guidelines for children that define an objective and evidence-based standard of care for the treatment of disorders, such as ADHD.
- Implementing pharmacy prior authorization algorithms and prospective and retrospective drug utilization review edits that require prior authorization for certain medications, such as ADHD medications, and identify appropriate drug use by age.
- Tracking member data related to prescribed medications using BayouCare, which maintains each member's medications, diagnoses, lab results, gaps in care and medication adherence, BayouCare also alerts case managers whenever ADHD medications are prescribed so they can monitor provider adherence to these requirements.
- Providing training to providers on the use of best practice guidelines and verifying compliance through clinical practice consultant outreach and analysis of pharmacy data
- Providing education to members and their caretakers through our *liveandworkwell.com* website, which provides a wealth of preventive, self-management and condition-specific medical/behavioral health education materials geared toward children, youth and their parents/caregivers.
- Developing protocols for screening and monitoring members receiving ADHD medications and requiring prescribers to conduct routine health screening and medical monitoring appropriate to the medication.

Best Practice Guidelines and Pharmacy Utilization Management

To ensure that members receive evidence-based care, we have adopted nationally recognized best practice guidelines for children, developed by the American Academy of Child and Adolescent Psychiatry, which define an objective and evidence-based standard of care for the treatment of ADHD, autism/other development disorders, conduct disorder, obsessive compulsive disorder, post-traumatic stress disorder, substance use disorders, anxiety disorders, bipolar disorders in children, depressive disorders, oppositional defiant disorder, reactive attachment disorder and suicidal behaviors.

Our online point of sale prior authorization system implements a drug to diagnosis edit that requires the prescriber to include a diagnosis appropriate to the prescribed medication. If the diagnosis is not appropriate to the medication, the system denies the prescription and indicates to the pharmacist that prior authorization is required.

We will translate these guidelines and the guidelines for children developed by the State into prospective drug utilization review (DUR) edits, prior authorization algorithms and retrospective DUR analysis parameters. For example, we will establish a prior authorization requirement that direct the pharmacists to contact the PCP to initiate a prior authorization request the first time an AHDH medication is prescribed for a member under the age of seven. The PCP will have to document the need for that

medication including, rationale, such as the assessment and diagnostic methods used in evaluating the child for psychiatric symptoms/illness, history of responsiveness of parent and/or teacher to non-psycho-pharmacological interventions and assessment and training of parents in evidence-based behavior management. In addition, we will require that children under the age of five receive evaluation by a psychiatrist prior to approval of ADHD medications not prescribed by a specialist.

Our prospective DUR program uses multiple algorithms to compare submitted prescription data with evidence-based guidelines to identify any potential drug issues or critical medication interactions. We compare prescription data with the member's profile data and prescription history. In the case of ADHD medications, our system applies prospective edits, such as preventing the pharmacist from filling prescriptions for ADHD medication for children under the age of seven. When a prescription triggers one of our prospective DUR edits, it is flagged and the submitting pharmacist receives a message in real time that indicates either a hard reject of the prescription or a "soft" warning that prompts interaction and discussion with the prescriber to determine the appropriateness of the medication requested.

We routinely conduct retrospective DUR analyses to identify appropriate drug use by age. We will develop retrospective DUR algorithms specifically targeted at ADHD medication use that we will incorporate the State's guidelines. We will retrospectively look at utilization to detect medication adherence, such as gaps in use of ADHD medications or over utilization of ADHD medications. We will identify prescribers whose prescribing patterns exceed acceptable parameters. We will provide education to the identified prescribers through the care coordination team, practice management consultants, peer to peer contact, and written materials.

Alerting Case Managers when Certain Medications are Prescribed

We identified prescribers and members that were using high cost XOLAIR off-label. Through the State pharmacy committee, we encouraged prior authorization of XOLAIR and 26-28 other high-cost drugs that should only be ordered for specific diagnosis and for specific reasons. We implemented pharmacy point-of-sale prior authorization to prevent this misuse.

BayouCare provides a comprehensive view of the relevant issues and care needs to support the member's optimal health and achievement of health goals. It provides access to pharmacy data and maintains each member's condition list, medications, service dates and outcomes, history, provider visits, diagnoses, issues, progress/case conference notes, lab results, gaps in care and medication adherence. BayouCare will alert case managers whenever ADHD medications are prescribed so they can monitor provider adherence to these requirements. BayouCare provides reporting that allows us to audit provider compliance.

Provider Training and Verifying Compliance

As a strong supporter of the use of evidence-based practices in service delivery, we have found that clinical outcomes are much more likely to be positive when providers are using treatment modalities that have been proven to be effective.

Our behavioral health medical director will be available to the PCP to discuss the prescribing criteria and provide additional education, if desired. Our behavioral health advocates are accessible to coordinate non-prescription resources for the member.

As part of initial and ongoing provider training, CPCs will ensure providers understand the process and required elements necessary to prescribe ADHD medications and educate providers

on how to apply best practice guidelines in the treatment of children with ADHD. We will provide the prescribing requirements and best practice guidelines through our secure provider portal, BayouCloud, in our *Provider Administrative Guide* and we will include the requirements in provider contracts.

Through regular provider meetings, clinical practice consultants will use BayouCare reporting to review practice medical records to verify compliance with best practices and ADHD medication use. Additionally, we will regularly review pharmacy data for these drugs by members to ensure we receive the information from the prescribing physician documenting the need for the medication.

Member Education

We also will provide education to our members and their caretakers on the appropriate use of ADHD medications. Accessible through our member portal, *myuhc.com*, our *liveandworkwell.com* website provides a wealth of preventive, self-management and medical/behavioral health education materials geared toward children, youth and their parents/caregivers. Information includes comprehensive condition-specific centers, articles, webinars, latest news in health care, guides, and resource links on topics such as health management, teen alcohol and drug abuse, recovery, planning for college, preventing sexually transmitted diseases, stress management, eating disorders and bullying.

Member activity on our *liveandworkwell.com* ADHD site grew 21 percent during 2013.

Through *liveandworkwell.com*, members can take self-assessments, locate community resources, and identify network clinicians and facilities. Information is provided which relates to symptoms, diagnoses, tests, treatment and prevention related to conditions. Clinical topics such as depression, stress, ADHD, autism, post-traumatic stress disorder, grief and alcoholism are included. Support focuses on improving coping capabilities and helping members and families make the most of their lives.

Screening and Monitoring

Routine health screening and drug monitoring can help mitigate the risk of serious conditions in members taking ADHD medications. We will generate letters to the prescribers as a reminder that they conduct medical monitoring. We will provide a tool on our provider portal to assist the prescribers. The tool will include a checklist to determine whether the member is at high or low risk for developing adverse effects and a list of clinical and laboratory procedures that should be monitored. As an example, protocols for ADHD medications may include monitoring, such as the following:

- Complete Blood Count (CBC)
- Complete Metabolic Profile (CMP), Lipid Panel
- Pregnancy test
- Blood pressure, pulse rate, height, weight and body mass index measurement
- Electrocardiogram (EKG)

In addition, we will analyze pharmacy and lab data to identify individuals who are receiving ADHD medications, but may not be receiving the appropriate laboratory monitoring. We will

send reminders to providers about the need to conduct laboratory screening for the identified members.

N.9 Identify how you will assess the quality and appropriateness of care furnished to enrollees with special health care needs. (5 points)

As outlined in our Chronic Care Management Program (CCMP), we maintain a comprehensive, patient-centered, integrated clinical model to support the continuity and coordination of care for our members with special needs. The CCMP, as overseen by the chief medical officer, Dr. Ann Kay Logarbo, is monitored by our Healthcare Quality and Utilization Management (HQUM) Committee, which is a subcommittee of our Quality Management Committee (QMC), ultimately accountable to our board of directors. Through the HQUM, a multi-disciplinary clinical staff monitors process and outcomes indicators for our CCMP overall and specifically in terms of care for members with special needs. The HQUM is empowered to implement improvement initiatives when monitoring of critical quality indicators identifies opportunities to improve care or services rendered.

As part of our CCMP, we adopt industry standard clinical practice guidelines to assist our case managers and medical directors, and our network physicians in providing evidence-based care to our members with special health care needs. Our Provider Advisory Committee (PAC), comprised of participating network providers, reviews and approves our clinical practice guidelines at least annually or when they are updated. Guidelines are distributed to our providers through our newsletter, provider portal, and through interactions with our clinical practice consultants and medical directors. Internally, our clinical guidelines are provided through our clinical management systems and resource databases. Adoption of these guidelines enables our quality management and performance team and health services team, under the supervision of our chief medical officer, to monitor at the individual and population level the quality and appropriateness of care rendered to members with special needs.

Process indicators to be monitored include:

- Total number of members in case management
- Number of members enrolled in CCMP
- Number of members dis-enrolled from program and explanation as to why they were disenrolled
- Participation rates in CCMP and complex case management activities
- Member functioning—quality-of-life measures
- Emergency room visits/1,000
- Hospital admissions/1,000
- Member satisfaction with CCMP and complex case management programs

Examples of clinical conditions potentially identifying a member with special needs are listed below, along with the adopted clinical practice guidelines and possible measures of quality, to illustrate the alignment of approaches that rely on evidenced based care.

Targeted Chronic Condition	Clinical Practice Guidelines	Quality Measures
Asthma	2007 National Asthma Education and Prevention Program Expert Panel Report 3 Guidelines for the Diagnosis and Management of Asthma National Heart, Lung and Blood Institute www.nhlbi.nih.gov/guidelines/asthma/index.htm	▪ The number of ER visits and inpatient admissions by population (child/adult) ▪ Number of members with asthma who had asthma-related education in their plans of care ▪ Number of members with asthma who had a quality of life goal in their plans of care ▪ Number of members with asthma who had a self-management goal in their plans of care ▪ HEDIS Asthma Measures
Congestive Heart Failure (CHF)	2013 ACCF/AHA Guideline for the Management of Heart Failure American College of Cardiology/American Heart Association http://circ.ahajournals.org/content/128/16/e240.full.pdf	▪ Reduce unnecessary hospitalizations and health care costs ▪ Improve the health of the member ▪ Use of ACE Inhibitors/ARBs ▪ Use of Beta-Blockers ▪ Use of Aldactone ▪ Echocardiogram performed once a year
Coronary Artery Disease (CAD)	2011 AHA/ACC Guidelines for Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease American College of Cardiology/American Heart Association http://circ.ahajournals.org/content/124/22/2458.full.pdf	▪ Echocardiogram performed once a year ▪ Frequency of tests and distribution of values for total cholesterol, LDL, HDL and triglycerides ▪ Percent of members with at least one LDL cholesterol test in the past year. ▪ Percent of members with most recent LDL cholesterol below 130 ▪ Blood pressure range of values for most recent systolic and diastolic blood pressure reading, e.g., percent of members with most recent blood pressure below 140/90
COPD	Global Strategy for Diagnosis, Management and Prevention of COPD – 2014 Global Initiative for Chronic Obstructive Lung Disease (GOLD) http://www.goldcopd.org/uploads/users/files/GOLD_Report2014_Feb07.pdf	▪ Use of bronchodilators ▪ Use of corticosteroids ▪ Decreased use of oxygen ▪ Increase in exercise tolerance ▪ Increase SpO2 and decrease FIO2 ▪ Frequency of tests and distribution of values for total cholesterol, LDL, HDL and triglycerides. Percent of members with at least one LDL cholesterol test in the past year
Diabetes	Standards of Medical Care in Diabetes – 2014 American Diabetes Association http://care.diabetesjournals.org/content/37/Supplement_1/S14.full.pdf+html	▪ HEDIS measures: ▪ Hemoglobin A1c test ▪ LDL or LIPID panel test ▪ Nephropathy screening test or evidence of nephropathy ▪ Diabetic retinopathy eye exam ▪ Blood pressure

Targeted Chronic Condition	Clinical Practice Guidelines	Quality Measures
HIV/AIDS	Primary Care Guidelines for the Management of Persons Infected with HIV: 2013 Update HIV Medicine Association of the Infectious Diseases Society of America http://cid.oxfordjournals.org/content/58/1/1.full.pdf	▪ Percent of HIV members with at least two CD4 counts in a 12-month period ▪ Percent of HIV members with a viral load test every 4 months ▪ Number of members with a diagnosis of HIV infection or AIDS ▪ Number of members linked to community services ▪ Number of members who can remain at home, if desired
Sickle Cell Anemia	The Management of Sickle Cell Disease, 4th Edition National Heart, Lung and Blood Institute (NHLBI) National Heart, Lung and Blood Institute http://www.nhlbi.nih.gov/health/prof/blood/sickle/sc_mngt.pdf	▪ Members greater than 24 months of age who have at least one PCP or specialist evaluation during measurement period ▪ Member compliance with Hydroxyurea, an inexpensive medication that reduces the incidence of painful sickle cell crises ▪ Number of reduced ER visits ▪ Number of reduced inpatient admissions ▪ Number of reduced readmission rates ▪ Number of ischemic stroke and transient ischemic attacks ▪ Number of members with episodes of pain crisis and iron overload
Obesity	Dietary Guidelines for Americans, 2010 U.S. Department of Health and Human Services http://health.gov/dietaryguidelines/dga2010/DietaryGuidelines2010.pdf 2008 Physical Activity Guidelines for Americans U.S. Department of Health and Human Services http://www.health.gov/paguidelines/pdf/paguide.pdf	▪ Measure body mass index

Targeted Chronic Condition	Clinical Practice Guidelines	Quality Measures
High-risk Maternity	Guidelines for Perinatal Care, 7th edition American Academy of Pediatrics and American College of Obstetricians and Gynecologists Note: This resource is not publically available; a user ID and password are required to access the document via: http://www.acog.org/Resources_And_Publications Alternatively, the book can be purchased from the American Academy of Pediatrics website. http://ebooks.aap.org/product/guidelines-for-perinatal-care40442	▪ Delivery Outcomes ▪ Type of delivery ▪ Percent low birth weight ▪ Percent of NICU admits ▪ Program Measures ▪ Number enrolled in case management versus total eligible population ▪ Number assessed/stratified/reached versus total eligible population ▪ Trimester enrolled ▪ Number participating in pregnancy programs, e.g., Healthy First Steps, Baby Blocks, etc.
Co-Morbid Behavioral Conditions	2007 Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention Deficit Hyperactivity Disorder American Academy of Child and Adolescent Psychiatry http://download.journals.elsevierhealth.com/pdfs/journals/0890-8567/PIIS0890856709621821.pdf UHC Utilization Review Guidelines – Autism Spectrum Disorders Internal (Knowledge Library): http://kl/Content/Guidelines%20&%20Clinical%20Policies/Utilization%20Review%20Guidelines/Internal%20and%20External/Autism%20Spectrum%20Disorder_URG.doc External (*unitedhealthcareonline.com*): https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Medical%20Policies/Medical%20Policies/Autism_Spectrum_Disorder_URG.pdf Guideline Watch (November 2005): Practice Guideline for the Treatment of Patients with Bipolar	▪ Decrease in overutilization of ADHD meds that do not meet medical necessity ▪ Increase in children appropriately evaluated by BH prior to medication

Targeted Chronic Condition	Clinical Practice Guidelines	Quality Measures
Co-Morbid Behavioral Conditions	Disorder, 2nd Edition American Psychiatric Association http://psychiatryonline.org/data/Books/prac/Bipolar.watch.pdf 2007 Practice Parameter for the Assessment and Treatment of Children and Adolescents with Bipolar Disorder American Academy of Child and Adolescent Psychiatry http://download.journals.elsevierhealth.com/pdfs/journals/0890-8567/PIIS0890856709619687.pdf Practice Guideline For The Treatment of Patients With Major Depressive Disorder, Third Edition American Psychiatric Association http://psychiatryonline.org/pdfaccess.ashx?ResourceID=243261&PDFSource=6 Guideline Watch (September 2009): Practice Guideline for the Treatment of Patients with Schizophrenia American Psychiatric Association/ PsychiatryOnline Guideline Watch http://psychiatryonline.org/pdfaccess.ashx?ResourceID=243181&PDFSource=6 Guideline Watch (April 2007): Practice Guideline for the Treatment of Patients with Substance Use Disorders American Psychiatric Association/ PsychiatryOnline Guideline Watch http://focus.psychiatryonline.org/data/Journals/FOCUS/2693/foc00207000163.pdf	▪ Decrease in overutilization of ADHD meds that do not meet medical necessity ▪ Increase in children appropriately evaluated by BH prior to medication

In addition to using clinical practice guidelines to assess the quality and appropriateness of care and service rendered to our members with special health care needs at a system or population level, if any of our staff identify a potential quality of care concern, it is reviewed at the individual patient/provider level. We maintain a quality of care/peer review process in compliance with state and federal regulations. When a potential quality of care concern is identified, it is referred to our clinical quality team for review and investigation. Cases are then reviewed with the chief medical officer and if a deviation from standard practice as established

by clinical practice guidelines or a potentially preventable adverse outcome is identified, the case is presented to our Peer Review Committee (PRC).

Our PRC is comprised of participating UnitedHealthcare practitioners with a variety of clinical backgrounds. Based upon the PRC review of the case, a level is assigned and action is taken commensurate with the severity of the issue. All such issues are entered into our confidential database, QCare, where we are able to review a profile for individual providers who may have multiple quality of care concerns across all of our lines of business (e.g., Medicaid, commercial and Medicare). This allows us a comprehensive profile of a provider's performance, enabling us to make a determination regarding a provider's participation if an unacceptable quality of care trend emerges. Furthermore, upon a provider's tri-annual re-credentialing, this database is evaluated and providers who exceed our threshold for quality of care concerns are evaluated by our credentialing committee before a determination is made to re-credential.

We are committed to improving the quality of care and services we provide to Bayou Health program members and members enrolled in the Chronic Care Management Program (CCMP) in compliance with Section 8.0 and 8.2. To fulfill our mission of helping people live healthier lives, we follow our comprehensive Quality Improvement (QI) Program. Our member-centered foundation is the basis for our quality structure and is critical to improve the overall care and service levels we provide. This program is structured to enable us to systematically monitor and evaluate the quality and appropriateness of care and continually improve health outcomes for Bayou Health program enrollees.

Use of Evidence-based Guidelines

We use multiple evidence-based guidelines for both acute care and behavioral health that monitor and improve the quality of care provided by participating practitioners, in compliance with Section 6.39. We proactively encourage providers' use of evidence-based guidelines through mailings and through BayouCloud, our provider portal. We promote person-focused education and outreach through our care managers. Our QM and Performance Policy NQM-029 ("Clinical Practice Guidelines") defines the process used for review of local or nationally recognized clinical guidelines in the PAC and the QMC. This policy is currently in place and will be revised based upon new contract requirements. Otherwise the policy is reviewed at least every two years and updated as needed. On an annual basis, we measure performance against a minimum of two clinical guidelines for acute or chronic medical conditions, and two behavioral health conditions and provide the results to the State in the Quality Improvement Program Evaluation.

Improve Quality of Care

We support Louisiana's quality strategy through the following initiatives designed to improve quality of care:

Care Management: This program is based upon the premise that collaboration between the member, support systems and health care professionals results in the development of partnerships that promote targeted interventions and health care goals and contributes to improving health care outcomes. In Louisiana, RN case managers outreach to high-risk pregnancy members with high-risk conditions.

Chronic Care Management: This program is guided by the principles of our care model. Disease management members often receive condition specific education and interventions to

address self-management of chronic conditions to include asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), high blood pressure, obesity and sickle cell anemia.

Use of Clinical Guidelines: We promoted the use of evidence-based clinical guidelines to network providers and reduced the barriers to care that result from a reliable means to contact and communicate with members. Through the use of an auto-dialer program, we contact all new case management referral members and if the member answered, connected them with a live case manager. In addition, we encouraged members with chronic health problems to establish a medical home with a PCP that will provide holistic, coordinated care. We followed up this effort with heightened attention from the CPCs and distribution of the evidence-based guidelines toolkits to providers.

Coordination of Care: Postpartum health care visits provide the opportunity for health care providers to assess and educate parents on important components of newborn care and manage identified risk factors. These visits help evaluate ongoing medical and psychosocial needs for the mother and child and establish an ongoing health home to address current and future needs. Many women experience some degree of emotional liability in the postpartum period making timely care and behavioral health assessment critical for both the mother's and newborn's health. We assure continuity and coordination of care beyond delivery by encouraging members and providers to adhere to the recommended guidelines for postpartum care, for example:

- High-risk pregnancy case management outreach to members with high-risk conditions by RN case managers
- Our national Twitter handle @UHCPregnantCare targets our TANF audience who parallels Twitter's demographics. @UHCPregnantCare's messaging delivers health and wellness information relating to pregnancy, child birth and general health information applicable to pregnant women.
- Our Text4Baby educational program provides messaging throughout pregnancy related to prenatal care, health education, mental health information etc., including postpartum messaging.
- We launched the first enterprise Spanish handle in January. @UHCEmbarazada (UHCPregnancy) has the same content as @UHCPregnantCare, but the Spanish handle gives our audience the option to choose their preferred language. All promotional materials are offered in Spanish as well. Pregnancy Care Guidelines are posted on the *BayouCloud* provider portal.
- Automated calls are made to all post-partum members, which include a reminder to return to their OB/GYN four to six weeks for a post-partum visit.
- New Mom welcome packets are sent to all members which include a reminder for postpartum visits

Eliminating Health Disparities: We chose to focus on health care issues that disproportionately affect African-American over other races, including breast and cervical cancer mortality, asthma management and sickle cell disease. Though Louisiana ranks 40th in the United States in incidence of breast cancer, the state ranks second highest in mortality from the disease. Likewise, African-Americans are more likely to have asthma than their Caucasian counterparts. We implemented targeted outreach to increase breast cancer screening, the most effective way to

improve breast cancer mortality. We tackled asthma management in initiatives ranging from provider education about treatment to engagement of schools in facilitating compliance with asthma action plans for children. In addition, we focused on identification of members with sickle cell disease and referral of those members to its case management program.

Performance Improvement Projects (PIPs): We have active PIPs/focused studies on the following topics: asthma, breast cancer and ER diversion. The quality team monitors monthly progress on these projects. There is a collaborative group that meets quarterly to perform a barrier analysis and revise interventions as needed. This group includes a representative from behavioral health, pharmacy, care management and outreach.

Performance Measures: HEDIS measures are monitored on a monthly basis. During this process the team evaluates current interventions, discusses options for new programs, and determines how to combat barriers to care. Progress is documented on the QI Work plan and discussed with the PAC and the QMC.

Improve Efficiencies and Cost Effectiveness

Cost and efficiency are driven by three primary factors: benefits, provider fee schedules and effective UM (e.g., prior authorization, case management and preventive care). We closely monitor utilization and medical cost trends by annually evaluating our programs. We review health care and pharmacy trends and provide quarterly updates via the HQUM Committee, led by Dr. Logarbo. The HQUM monitors all clinical QI and UM activities and is designed to monitor health care trends and analyze any areas of improvement for member care/condition. The goal is to provide effective, cost efficient care to our underserved population.

Evaluating Program Effectiveness

We use analytic systems to design, collect, document and implement data to evaluate the effectiveness of the programs that serve Bayou Health program members with special needs. We profile providers by examining clinical and claims data, such as ER visits, hospital readmissions, lab and pharmacy encounters, claims, in and out-of-network specialty referrals and utilization by high-risk members. Our experience and knowledge of the program enables us to leverage the existing system configurations, data exchanges and interfaces already in place and provide efficiencies, expend fewer resources, and avoid interruptions to the continuum of care for members.

Analysis

Our data warehouse integrates medical, behavioral, pharmacy, financial, demographic and socioeconomic data to produce all of the reporting and analytics needed to conform to Bayou Health program requirements, including predictive analytics; provider information support; fraud, waste and abuse; and the management of utilization and medical outcomes.

Implement

Once an area for improvement has been selected, we use our data warehouse to pull information on the intervention groups. Our data systems can pull information on population characteristics such as: ethnicity, culture, language or compliance level (e.g., new member, consistently compliant, consistently noncompliant or variable compliance). Once the population is identified, proven interventions are selected and we address specific root causes or barriers. The timing and course of the intervention is taken into consideration when prioritizing interventions for implementation.

Evaluate

Our QM and Performance Policy (NQM 048) provides guidance for completing an interim and annual evaluation of the QI Plan to determine the effectiveness of the program which is approved by the QMC and the Board of Directors. The annual evaluation includes a thorough analysis and improvement plan for all elements of the QI Program.

Section O: Chronic Care Management Program

O.1 Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for Bayou Health. Include information on work you have conducted in other states, if applicable. Include how you measure success for each of the populations (i.e. 20% reduction in 30-day readmission rate for members with diabetes); any state models you plan to implement in Louisiana; and how you plan to partner with national, state, or community foundations to support this work. Your plan should include but is not limited to:

- How recipients will be identified for inclusion into the Chronic Care/Disease Management program, including populations of special interest to Louisiana e.g. reproductive aged women with a history of a prior poor birth outcome and members with Diabetes, HIV, Hepatitis C and sickle cell disease.
- How you identify which disease states/recipient types will be targeted for the Chronic Care/Disease Management program.
- How you identify members who require in person case management services.
- Plans to integrate with existing resources/programs in Louisiana as well as your plans to have case managers "on the ground" in addition to telephonic case management
- How the Chronic Care/Disease Management program will coordinate information and services with the PCP.
- Methods for case management in ways other than simply telephone management. These may include the use of pre-existing community organizations, community hubs, community health workers etc.
- How you engage patients (in person, mobile apps, telephonic) and explain your model of case management including what types of personnel (lay health workers, nurses, social workers) are providing case management.(20 points)

Chronic Disease Experts Speak At Nobel Peace Prize Forum

In March 2013, two of UnitedHealth Group's leading chronic disease experts, Deneen Vojta, M.D. and Richard Smith, M.D., addressed the Nobel Peace Prize Forum, raising awareness about the epidemic of diabetes and spreading the message about the threat that obesity and diabetes pose to global health and prosperity.

Dr. Vojta spearheaded UnitedHealth Group's partnership with the CDC and the YMCA of the USA to scale the U.S. National Diabetes Prevention Program, led the design and study of a scalable child obesity intervention, JOIN for ME, and partnered with Comcast to disseminate a reality television version of the Diabetes Prevention Program, a clinically proven lifestyle change program that can reduce the risk of developing type 2 diabetes in people with pre-diabetes. Dr. Smith directs a chronic disease initiative that works with the National Heart, Lung, and Blood Institute (a National Institute of Health) to fight heart disease and diabetes through the support of a global network of 11 Centers of Excellence.

In a recent (April 2014) press release announcing the "Well-Ahead Louisiana" health initiative, the Governor stated that in 2013, Louisiana spent an estimated $28 billion on the treatment and economic costs of primary chronic diseases, e.g., heart disease, obesity and diabetes. State leadership indicated that when Louisianians start making their own healthy decisions, future economic costs associated with chronic conditions could be reduced by $17.3 billion, coupled with a decrease of 600,000 chronic disease cases. Furthermore, smart and healthy living could add $62 billion to the State's economic output by 2050.

The 2013 America's Health Rankings® publication, sponsored by UnitedHealth Foundation, shows Louisiana ranked 46 of 50 states in premature deaths per 100,000. Deaths by cardiovascular disease (heart disease and stroke) and by cancer showed Louisiana ranked 46 and 48 respectively, and diabetes

ratings ranked Louisiana 48 of 50 states. Louisiana's ranking showed an upward trend for obesity (adults with a body mass index of 30 or higher) with Louisiana ranking 50 of 50 states, which translates to 34.7 percent of the adult population or 1.2 million obese adults in Louisiana. More than 1 million Louisiana adults reported they were physically inactive. Nationally, the rates for obesity-related chronic conditions are rising among younger adults, thus they will live longer with chronic diseases and related symptoms.

Population Health Chronic Care Management Program

In Louisiana, we are making the transition from a disease management model of targeted health care interventions to a new population health and person-centered, integrated care model featuring a Population Health Chronic Care Management Program (CCMP). Our CCMP touches our Bayou Health members who are at risk for chronic conditions across the entire care continuum, promoting healthy behaviors and self-management as well as providing care coordination and intense case management, improving quality of life while decreasing the use of higher intensity and costly services. Our CCMP program addresses our members' physical, behavioral and psychosocial needs using nationally recognized standards of care.

Our CCMP is a comprehensive, ongoing and coordinated approach to achieving positive outcomes. These outcomes include improving our members' clinical conditions and quality of life, and reducing unnecessary health care costs. To achieve these objectives, we offer rigorous, protocol-based clinical management in conjunction with intensive member education, coaching and monitoring—in short, our CCMP is a comprehensive system that incorporates the member, PCP and our health plan into one focused system with common goals.

Our population health person-centered CCMP is a whole-person-oriented approach based upon the risk stratification of different populations including but not limited those outlined in Section 6.39.1:

- Asthma
- Congestive heart failure (CHF)
- Diabetes
- HIV/AIDS
- Hepatitis C
- Obesity
- Sickle cell disease (SCD), focusing on diagnosed members who are high utilizers of the ER and inpatient services

In addition, per RFP section 6.39.3, we will include a minimum of one of the following chronic conditions in our CCMP:

- Chronic obstructive pulmonary disease (COPD)
- High blood pressure as a precursor to coronary artery disease (CAD) and stroke
- Low back pain
- Chronic pain

Chronic Pain Management
In Louisiana in 2014, we presented to DHH the need for restricted use of pain management and its potential savings, which is currently under consideration by the State. With certain diagnosis codes, chronic pain management is a much more affordable alternative (and effective) than continual narcotic use. It also allows the member to function independently.

Our population health person-centered CCMP will broadly identify and appropriately support all members who are at risk for adverse health outcomes, regardless of diagnosis. To effectively execute and personalize outcome-specific plans of care, we use various data sets to identify specific member needs and to stratify members into various levels of intervention. Our proprietary predictive modeling tool, Impact Pro, screens and analyzes claims/utilization data to identify members who are at risk for adverse health outcomes with diagnosis such as asthma, diabetes, CHF, COPD, CAD and other chronic conditions.

Our National Experience with Chronic Disease Management and Prevention

We are a national leader in chronic disease management and medical home initiatives with more than 30 years of experience offering chronic disease management programs. Nationwide, we are making the transition from a disease management model of targeted health care interventions to a person-centered, integrated care model featuring chronic case management programs focused on population health. Whereas disease management is aimed to help members prevent the worsening of a single chronic condition, a population health-focused model is a whole-person-oriented approach based upon the risk stratification of the population. It touches members across the entire care continuum, promoting healthy behaviors and self-management as well as providing intense care coordination and case management. Our Bayou Health person-centered, integrated care model aligns well with our mission of helping people live healthier lives.

Our integrated chronic disease management and person-centered case management philosophy:

- Offers comprehensive, member-specific interventions
- Engages an interdisciplinary care team
- Measures, reports and analyzes outcomes
- Improves quality of life
- Promotes cost efficiencies

Our Experience Shows Measureable Positive Results of Disease Management Initiatives

Chronic disease management programs can have a significant impact on the cost and health outcomes for Medicaid populations across the nation. In Louisiana, we are making progress managing high-risk pregnancies by referring members to Healthy First Steps, our high-risk pregnancy case management program. Our intensified focus on SCD began with telephonic outreach to connect members to providers and to enroll them in case management and will be expanded, as described later in this section, to better address the needs of these members.

The following table provides evidence of the success we are having helping our members achieve positive outcomes through existing chronic care/disease management programs. We can leverage our national experience, the work done in other markets as well as the work done in Louisiana to ensure we continue to use time-tested best practices for our Louisiana Bayou Health members.

Louisiana Chronic Disease Management Experience

High-risk Pregnancy Targeted Case Management	
Program Description	**Success Measures**
Healthy First Steps is a high-risk case management program where Healthy First Steps case managers monitor and coordinate care for members at greatest risk for pre-term labor, pre-term delivery or adverse maternal-fetal outcome.	From Q1 – Q4 2013, our efforts in Louisiana: ▪ Decreased prematurity birth rate from 12 percent to 10.5 percent ▪ Increased average gestational age from 38.0 to 38.2

Sickle Cell Disease Management	
Program Description	**Success Measures**
This is a case management and outreach initiative where we provide education and steer members to a hematologist who can effectively manage their condition, including the use of hydroxyurea and transcranial ultrasound in children.	Program began in Louisiana in June 2014 with 21 members and results are currently being monitored.
Asthma Case Management	
Program Description	**Success Measures**
The asthma case management program helps members obtain comprehensive care for asthma. We have identified the benefit of asthma educators through the pilot programs with Our Lady of the Lakes (OLOL) and HEAL and will offer this statewide as a value-added member program to moderate-severe asthmatics enrolled in our case management programs.	In Louisiana: ▪ Lowered inpatient costs nearly 34 percent from $34,474 to $11,692 post-enrollment (November 2013, target population) ▪ Reduced ER visits 38 percent and cost mean went from $542.50 to $261.96 (December 2013-July 2014; pilot programs)
Accountable Care Community (ACC)	
Program Description	**Success Measures**
We inform and educate our members, particularly those with special health care needs, about the benefits of transitioning into one of our local ACCs. ACC providers are active users of our Population Registry as well as our BayouCare clinical platform, which is designed to share member-specific information electronically with the member's interdisciplinary care team. We currently have 18 practices, representing 56,574 members, in Louisiana ACCs.	In Louisiana, we have had success with the implementation of our ACC integrated model and performance metrics indicate positive health outcomes for our members. All ACC practices, statewide ▪ Decrease inpatient admission rate 15.9 percent from 101.8/1,000 to 85.6/1,000* ▪ Decrease inpatient readmission rate 16.1 from 20.1/1,000 to 16.9/1,000* ▪ Decrease ER admission rate 10.3 percent, from 689.4/1,000 to 618.1/1,000* Select Louisiana practices ▪ Practice A – Decreased inpatient admission rate 38.3 percent* ▪ Practice B – Decreased inpatient readmission rate 12.2 percent* ▪ Practice C – Decreased ER admission rate 18.7 percent* *All data compared from CY2013 actual versus April 30, 2014 actual

Chronic Disease Management Experience – Louisiana Bayou Health and Other States

Program Description	Success Measures
High-risk case management (HRCM) is a specialized person-centered program for members identified as high risk. The goal of HRCM is to address unmet member needs and provide education and support to improve member self-management skills and member quality of life. Members appropriate for HRCM are assigned a case manager who is responsible for member engagement and assessment. The case manager collaborates with the member, the member's caregiver, PCP, additional care providers (including behavioral health providers) and community resources to implement and monitor the plan of care.	From June to November 2012, we: ▪ Reduced ER visits 45 percent ▪ Increased PCP utilization 11 percent ▪ Reduced inpatient utilization by 19 percent for members who had an indicator that their goals were met within 90 days of enrollment into HRCM program
Arizona Medicaid -Tech Plus Touch Congestive Heart Failure Case Management Program	
Program Description	**Success Measures**
This is an innovative high-tech, high-touch case management program focused on hospital readmission reduction for members with CHF. We partner with telemedicine, ACC teams, United Clinical Services, utilization management staff and Preferred Homecare (home health care/DME vendor). Case managers monitor changes in weight and blood pressure, review findings with members, and coordinate follow-up care with primary care/specialty providers. We inform targeted providers about the program, members enrolled, gaps in care and suggested clinical interventions as needed.	▪ Reduced readmission rates from 20 percent to 8 percent for targeted population (Timeframe: 2014)
Texas Medicaid - Asthma and Diabetes Chronic/Disease Management	
Program Description	**Success Measures**
Chronic care/disease management program for high-risk STAR+PLUS members who have physical and mental disability and who qualify for Social Security Income (SSI). Chronic care/disease management program goals include: ▪ Increase compliance with appropriate asthma medication use (HEDIS ASM measure) ▪ Increase annual diabetes testing (HEDIS HbA1c measure) Chronic care/disease management program interventions included: ▪ Dedicated team of nurses conducted telephonic outreach and face-to-face visits with members and providers of noncompliant members and distributed asthma treatment guidelines. ▪ Mailed reminder letters and sent a letter to all providers with members with gaps in care. ▪ National house call practitioners conducted home visits.	▪ Increased ASM medication compliance rate from 69.2 percent to 80.7 percent ▪ Increased HbA1c testing rate from 75.54 percent to 83.20 percent ▪ Reduced cost for members with asthma by an average $13.19 PMPM ▪ Reduced the cost for members with diabetes by an average of $2.32 PMPM (Cost savings is based upon a comparison of claims for January - August 2013 versus September - December 2013)

Hawaii Medicaid - Diabetes Chronic/Disease Management	
Program Description	**Success Measures**
For the Hawaii QExA program, chronic care/disease management program interventions include: ▪ Member interventions: quarterly DM mailings to members emphasizing the importance of HbA1c testing and diabetes control and self-management. ▪ Provider interventions: distributed evidence-based practice guidelines and member care opportunities to PCPs and sent regular mailings to PCPs with lists of their members who have not received certain critical diabetic services and requests for verification that services were completed by the end of the year.	For reporting years: 2010 – 2013, we achieved consistent improvement in HEDIS measures, including: ▪ Increased HbA1c testing by 13.88 percent ▪ Increased LDL screening by 16.17 percent ▪ Increased eye exams by 19.54 percent ▪ Increased HbA1c below 7 by 10.14 percent
Rhode Island Medicaid - High-risk Pregnancy Targeted Case Management	
Program Description	**Success Measures**
For the Healthy First Steps program for high-risk pregnant members, interventions include: ▪ Member education ▪ Assistance with access to community resources, including behavioral health support for members identified with substance abuse and mental health issues ▪ Assistance with scheduling postpartum and well-baby visits ▪ Every new mom is offered a postpartum home visit	For reporting years 2010 – 2013, we improved HEDIS prenatal and postpartum measure rates, including: ▪ Increased timely prenatal care 3.29 percent ▪ Increased timely postpartum care 11.10 percent
Mississippi Medicaid – Sickle Cell Disease Chronic/Disease Management	
Program Description	**Success Measures**
We collaborate with the Mississippi Sickle Cell Foundation, Cure Sickle Cell Foundation, Dr. Aaron Shirley and University of Mississippi Medical Center. The program targets non-compliant members with a primary diagnosis of SCD and high ER utilization. Program interventions include: ▪ Disease education, disease management recommendations and ongoing follow-up by a case manager ▪ PCP re-assignment, sickle cell clinic appointment assistance and transportation assistance, as needed ▪ Medication management (assessment of hydroxyurea compliance and alternative pain management options) ▪ Health assessments and other educational needs were performed as applicable ▪ Educational materials mailed to members' home addresses ▪ Referral to other medical/behavioral services ▪ Support in the ER from an on-site, hospital-based case manager	From January 2013 to present, we: ▪ Reduced ER visits 74 percent for targeted members

Tennessee Medicaid - Congestive Heart Failure (CHF) Targeted Chronic/Disease Management	
Program Description	**Success Measures**
The TennCare CHF targeted chronic/disease management program includes: ▪ Identify and enroll all members with CHF into case management ▪ Stratify the population for acuity of disease ▪ Develop a plan of care for members in conjunction with a PCP and cardiologist ▪ Provide high-acuity members with electronic home scales and biometric monitoring systems ▪ Educate members and providers to follow best practice treatment in CHF management	From January 2011 to October 2013, we: ▪ Reduced CHF related hospitalizations 38 percent ▪ Reduced ER visits 17 percent

The member and his or her family, friends and community support system are at the center of our CCMP. Our proposed CCMP meets RFP section 6.39 requirements and offers a comprehensive, integrated approach to help members establish and maintain a stabilized, improved state of health and prevent disease-related complications.

The CCMP is fully integrated with our other clinical support programs, ensuring the coordination of clinical resources across the continuum of wellness, health and medical decision support and care and chronic care management. Alignment with the members' own personal health goals and preferences is key to engagement. This model is person-centered and engages the family whenever appropriate to support the member's goals.

Partnering with National, State and Community Foundations

Our mission is to help people live healthier lives and help make the health system work better for everyone. We work collaboratively with health care professionals and a broad range of national, state and community foundations to help make Louisiana a healthier place, make health care better, strengthen communities, expand access to quality health care and make a difference in Bayou Health members' lives. Through our partnerships with national, state and community foundations, we make sure prevention-focused health care and community prevention efforts are available.

We maintain an important synergy between our business interests and our commitment to social responsibility through employee involvement, investing in local communities, providing funding for grants and programs and more. To further demonstrate our commitment to a person-centric culture, UnitedHealth Group created a new National Health Plan Advisory Board to improve the way we deliver services to our Medicaid, long-term care and Medicare members. The National Advisory Board, unique in its charter and membership, develops strong relationships with our consumer groups by demonstrating a commitment to issues important to our health plan participants and consumer groups. The National Health Plan Advisory Board operates as an independent advisory committee and comprises distinguished and highly respected health care consumers, providers, community advocates and thought leaders.

The following business innovations provide evidence of our partnerships with national, state and community foundations, empowering members and their families, strengthening communities and changing health care and the health care experience to make it simpler and more effective and accessible:

- ***JOIN for ME[SM]:*** This program engages children (and their caregivers) who struggle with obesity in a series of group sessions to achieve healthier weights through healthier family food choices, increased activity and lifestyle improvement tracking.
- ***Diabetes Prevention and Control Alliance (DPCA):*** DPCA is a first-of-its-kind model for tracking diabetes, prediabetes and obesity. DPCA was launched in 2010 through a partnership with UnitedHealth Group, the YMCA and retail pharmacies.
- ***Sesame Workshop Partnership:*** The *Healthy Habits for Life* partnership between UnitedHealthcare and Sesame Workshop, the nonprofit educational organization behind Sesame Street, offers tools and resources to help parents gain a greater understanding of the relationship between healthy habits and children's health growth.
- ***4-H Eat4Health Program:*** National 4-H Council and UnitedHealthcare partnered with nine State Cooperative Extension 4-H programs, including Louisiana, to engage youth and their families in 4-H Healthy Living through the Eat4Health national initiative. Louisiana 4-H reached 7,211 youth and families through summer camps, the Louisiana State Fair and other statewide healthy living events and activities.
- ***Louisiana Alliance of Boys & Girls Clubs:*** We partnered with the Louisiana Alliance of Boys & Girls Clubs to host community forums to discuss the issue of childhood obesity and the JOIN for ME program.
- ***Foundations:*** United Health Foundation is a not-for-profit, private foundation dedicated to improving health care services for those in challenging circumstances and enhancing community well-being. In July 2014, Dr. Logarbo was featured in a Community Health Hero segment presenting an interview on the state of Louisiana's women and baby health. Community Health Heroes is a TV program dedicated to relaying pertinent information about health and wellness issues in the New Orleans community. The show is underwritten by the United Health Foundation and new episodes premiere monthly on New Orleans Access TV (NOA-TV).

Identifying Members for Chronic Case Management

Identification through risk profiling and risk stratification and early intervention is particularly important for high-risk members and those at-risk for chronic diseases. Our initial health risk assessment (HRA) and our predictive modeling and stratification system are our primary tools for identifying members for the CCMP and members who have comorbid medical and behavioral health issues.

We have an extensive outreach program that supports identification and referral for CCMP services. Our case management staff collaborates with other community partners, such as program case managers, clinic staff, other health care team community partners, to identify members. In addition to claims and pharmacy data, we integrate authorization and pre-certification information into our CCMP identification stratification methodologies. For members transitioning into UnitedHealthcare from another MCO or program, our transition coordinator is able to identify members for participation in CCMP through her review. Additional identification strategies beyond risk profiling include:

- ***Enrollment Data/HRA:*** We reach out to all new members not identified as high risk during enrollment complete a telephonic HRA; high-risk members (medical and behavioral) are escalated. If a member has difficulty with completion of the tool or speaks another language, special arrangements are made to complete the HRA. We will

offer an online version of the HRA via *myuhc.com* and mobile devices, e.g., smartphone or tablet. Providing an online HRA offers members an additional choice for how they engage with us.

- ***Comprehensive Health Status Assessment (CHSA) Results:*** CHSA results provide member-specific information, e.g., strength-based preferences, medication needs, mental health, substance use, ability to perform activities of daily living, housing needs, barriers to meeting goals, etc. to our case managers to assist them in developing a plan of care.
- ***Service Utilization Triggers:*** Inpatient census, ER reports, hospital discharge summaries, service authorizations and transitional coordination of care requests are triggers for review.
- ***Provider Referrals:*** Providers are educated on case management and CCMP programs and the process to refer members who are high risk and vulnerable for case management and CCMP services.
- ***Member Self-Referrals/Family Referrals:*** Members/families receive information on the availability of our care coordination/case management programs and CCMP and the process for members to self-refer to these programs. We may receive referrals by phone, fax, mail, email or through our member and provider portals. Community nurses at our Accountable Care Communities (ACCs) also refer members for case management services.
- ***Special Needs Populations:*** We accept referrals for members in special needs populations, e.g., pregnant, ventilator dependent, members having targeted chronic conditions defined by contractual requirements.
- ***State or Other Local Government Referrals:*** We accept referrals from state and other local governments identifying special populations or high-risk members.
- ***Other Referral Sources:*** Referrals are received for case management and CCMP from multiple other sources, including but not limited to: member services staff and outreach coordinators, health wellness and education programs, ER staff, community programs and hospital discharge planners.

Assessments

Assessments systematically drive identification of person-centered needs/goals/interventions to achieve best practices in chronic disease management.

Health Risk Assessment
We conduct a telephonic HRA for new members. The HRA includes:

- Complete demographic information
- Emergency room utilization in the last year
- History of hospitalizations in the last year
- Presence of co-morbid chronic medical and behavioral health conditions
- Ability to perform activities of daily living
- Perceived risks
- Self-reported health status
- Strengths-based needs and preferences

Health Risk Assessment

Risk identification begins with an HRA. We make it a priority to conduct an HRA for each member to align them with appropriate interventions, thus maximizing the impact of our CCMP efforts. Our integrated HRA is an integral part of our member outreach efforts, inbound member and outbound calls workflows and provider partnerships. The HRA tool is algorithmically designed to assign population health stratification levels and used to prompt further discussion regarding a member's current and historic clinical, behavioral and

socioeconomic needs so that we can align members with appropriate intervention approaches and maximize the impact of services provided.

The HRA reviews existing knowledge gaps and culturally sensitive insights that may influence health outcomes. We work with our provider network to identify members with special health care needs and use this information in the stratification, assessment and care planning. In the event a member calls into member services and has not completed an HRA, the system will route the member to a qualified staff member to complete the HRA in addition to addressing the member's reason for calling. The HRA data helps us identify members with risk factors that indicate the need for additional services, such as care coordination, case management or CCMP. Examples of risk factors include:

- Members with special health needs, e.g., diabetes, HIV, Hepatitis C and sickle cell disease, cancer, stroke, transplant, spinal cord injury or serious behavioral health conditions
- Over-utilization of services, e.g., multiple inpatient admissions or ER visits within the past six months
- Under-utilization of services, e.g., members who do not have a PCP or have not visited their PCP within the past year
- Members with complex or co-morbid medical and behavioral health conditions

The HRA is an initial assessment tool used for new and existing members to identify a member's health risks. Based upon the member's response to a series of questions, the tool assigns a score that corresponds to a population health level, as illustrated in the below figure.

Comprehensive Health Status Assessment

In addition to the HRA, for at-risk and high-risk members, our cross-trained physical/behavioral health professionals (including Healthy First Steps staff) use comprehensive assessments to screen for co-morbid physical and behavioral health conditions. We document members' health history, assess their health literacy status and screen for substance abuse, depression and cognitive impairment, as needed. Critical to each member's health is an assessment of his or her social supports and needs as well as documenting preferred language and geography. To help with this, family members, medical providers or others are interviewed and notes are documented in the member's plan of care.

The comprehensive health status assessment (CHSA) consists of two major components:

- A review of the following: the member's biopsychosocial needs, their perception of their current health status, preventive services, medical and BH chronic conditions, medications and social history
- Comprehensive functional assessment of activities of daily living (ADLs) and instrumental ADLs (IADLs)

The CHSA paints a holistic view (i.e., psychological, environmental, emotional, spiritual, genetic predisposition and lifestyle choices) of the

Comprehensive Reassessments
The following needs or conditions may warrant a reassessment of a member:

- Hospitalization
- Significant change in medication
- Change in, or loss of, a caregiver
- Medical, social, environmental or BH crisis
- Excessive ER use
- Major changes in the member's medical, psychosocial or behavioral health

member's overall health state. Members who report certain chronic conditions or who respond positively to behavioral health screening questions are prompted to complete an in-depth review of the particular condition identified. For members who respond positively to the behavioral health screening questions, we conduct a Patient Health Questionnaire (PHQ)-9 screening.

Comprehensive Reassessments

We complete reassessments when the member's condition or event warrants a member reassessment. We will incorporate the results of reassessments into the Bayou Health member's plan of care and distribute the plan of care to appropriate interdisciplinary care team members, including members and their families (with the member's consent).

Risk Stratification and Data Analytics

Our multi-dimensional, episode-based predictive modeling tool, Impact Pro, compiles information from multiple sources, including claims, laboratory and pharmacy data and uses it to predict future risk for intensive care services. Impact Pro uses a variety of evidence-based algorithms and models to predict which members are at greatest risk for severe health care problems in the future. Impact Pro's automated algorithms forecast future health risk and stratify high-risk members and provide information for us to help build the intensity of case management interventions—crucial data analytic capabilities that assist in the production of targeted reports and, in turn, effective member interventions. Algorithms identify members who have a history of ER use, repeat hospital admissions, high utilization of medical outpatient services, potential quality of care issues or an indication of multiple providers of services that appear to lack coordination.

Risk scoring and the stratification system within Impact Pro allows us to identify cohorts of members with multiple chronic diseases and behavioral health issues and to support enhanced case management by targeting the highest risk members and gaps in care. Case management staff evaluates this information and identifies members with the highest level of risk for further assessment. An "Overall Future Risk Score" is assigned to each member and represents the degree to which the CCMP has the opportunity to have an impact on members' health status and clinical outcomes. This assists our case managers in identifying members who are most likely to benefit from interventions.

Ongoing risk can be evaluated through service utilization triggers, practitioner referrals and sophisticated claims analysis. Through careful risk profiling, we have an early warning system to identify members who are at risk for requiring higher levels of care at a later date. By reaching out to these members, we can provide the services needed to support optimal health in the setting of the member's choice.

Risk assessment and stratification begin with the assessment process. As claim, service authorization and predictive modeling data become available, we use these analytic tools and data to further predict risk:

- ***Significant Episode Cluster Activity (SECA)*** reports identify members with four or more ER or two or more admissions within a 6-month period.
- ***Blended Census Report Tool (BCRT)*** identifies and tracks members in facilities, including readmissions for the same reason within 10 days.

The following illustration shows our population health risk stratification groups—general or most vulnerable—and the corresponding subgroups:

[redacted]

Our person-centered model of care is based upon population health, which considers the health of groups of individuals with the goal of improving health across the populations rather than focusing on disease states.

Within our *General* category, we include programs, such as wellness, low risk maternity, health risk management and care coordination. Members within the wellness program are identified by predictive modeling as meeting the following criteria: no identified health risks through telephonic HRA or claims history, no identified chronic conditions and no indication of pregnancy. Members in our low risk maternity, health risk management and care coordination programs are identified as not meeting the wellness or most vulnerable categories and identified using predictive modeling as meeting the following criteria:

- (If not pregnant) may be eligible for the health risk management program. We enroll individuals with chronic disease prevalent in our member population or who are using significant health resources in their regional population. We use clearly defined criteria to sub-stratify these members into high, medium and low categories; report this information in our annual program description and provide the minimum-required interventions specified in the RFP.
- (If pregnant and not high risk) member is eligible for the low risk maternity program.

Our *Most Vulnerable* members are medically fragile and are offered programs, such as: chronic care, high-risk pregnancy or complex case management—enrollment is optional for members. Using predictive modeling, referrals and HRAs to identify our most vulnerable members, these members are identified as being part of the top 5 percent of members, excluding high-risk maternity members, and are most at risk for adverse outcomes.

- Members identified as eligible for the chronic care program are not pregnant and have complex chronic conditions with multiple identified health risks or needs. They may have co-occurring mental illness and substance abuse or co-morbid physical and behavioral health conditions.
- Our most vulnerable members who are pregnant may be eligible for the high-risk pregnancy program.
- Members identified as eligible for the complex case management program are not pregnant and have high risk, unique or complex needs. These members may have co-occurring mental illness and substance abuse or co-morbid physical and behavioral health conditions. We identify these members using utilization reports, such as a high pharmacy user or those who exceed the ER threshold defined by the State.

Targeted Disease States and Recipient Types for CCMP

At a minimum, we offer programs in our CCMP for asthma, CHF, diabetes, HIV/AIDS, Hepatitis C, obesity, SCD and will target other conditions, such as, hypertension (as a precursor to coronary artery disease), COPD, high-risk pregnancy and ER overutilization, prevalent in the Bayou Health population.

We identify and target specific conditions for the CCMP as a result of:

- Department of Health and Hospitals (DHH) priorities
- Their prevalence in members and populations based upon data analytics
- Our ability to affect outcomes
- Their potential financial impact

The DHH website lists the following chronic disease-related statistics for the state:

- Approximately 208,000 adults or seven percent of adults in Louisiana have been diagnosed with diabetes.
- African Americans have the highest prevalence of diabetes, with a nine percent diagnosis rate, compared to five percent of Hispanics and six percent of the white population.
- Nearly one out of four adults in Louisiana is obese.
- One in four adults in Louisiana a current smoker and one in four children tries cigarettes by the 6th grade.
- Cardiovascular disease is the leading cause of death in Louisiana, accounting for almost 40 percent of all death in the state

All Conditions under Case Management

Population health case management services and programs are made available to individuals risk stratified as our most vulnerable members, comprising the top five percent of utilizers, including those with frequent or inappropriate ER utilization and inpatient stays, high-risk pregnancy case management and members with significant impairment in one or more of the IADLs. In addition, we target members with comorbid conditions to predict future exacerbation of their condition. While we have standardized, robust clinical programs, we customize our targeting based upon the particular characteristics of members in the Bayou Health program as well as State requirements.

Program Goals:

- Locate and enroll eligible members into case management and CCMP
- Reduce ER visits
- Reduce hospital inpatient admissions and readmissions
- Link members to a PCP, medical home or ACC

Measures:

- Total number of members in case management
- Number of members enrolled in CCMP
- Number of members disenrolled from program and explanation as to why they were dis-enrolled
- HEDIS measures
- Participation rates in CCMP and complex case management activities
- Adherence to prescribed medical treatment regimens
- Influenza Immunization: percent of eligible members who received an immunization or refused immunization during the recommended calendar period
- Member functioning—quality-of-life measures
- ER visits/1,000
- Hospital admissions/1,000
- Physician visits
- Member satisfaction with CCMP and complex case management programs
- Percent of eligible members who received an immunization or refused immunization during the recommended calendar period

Our CCMP and disease management activities are not limited to those listed below or those targeted in the RFP. We continually assess the population health needs of our membership and address the specific health needs of all of our members. In addition, the only way to truly determine the quality of our CCMP is to measure it; therefore, we have set specific goals for targeted CCMP conditions and associated measures. We are making progress in targeted areas, such as SCD and high-risk pregnancies, as noted in the following overviews.

Sickle Cell Chronic Disease Management

Our national clinical team has significant experience managing the care of members with SCD, and therefore they understand the unique needs of these members. We have leveraged this team's expertise to develop an SCD program that enhances our person-centered clinical model by offering timely SCD-specific interventions and resources, which are tailored to individual member needs. Our SCD program addresses the challenges unique to each stage of life—from newborn through adulthood—to mitigate disease progression and complications and improve the quality of life for members with SCD. Our SCD expertise includes:

- Associate medical director Dr. Lanetta Jordan, a world-renowned expert in sickle cell disease, helped develop our SCD program. She participated in the development of national SCD evidence-based guidelines sponsored by the National Institutes of Health.

Sickle cell program goals include:

- Improved function and quality of life for members with SCD
- Successful transition from pediatric to adolescent and adult condition management
- Measurable decreases in ER visits, inpatient admissions and readmission rates
- Measurable decrease in the overall cost of care for members with SCD
- Improved hydroxyurea adherence
- Reduced episodes of pain crisis and iron overload
- Reduction in ischemic stroke and transient ischemic attacks
- Delayed disease progression

- Our national clinical team has a combination of Medicaid experience and hands-on experience managing members with SCD.
- Sickle cell disease medical director Dr. Paul Monte is American Board of Internal Medicine-certified and has significant experience managing patients with SCD in a hospital setting. Dr. Monte will oversee our national SCD program.
- National SCD expert panel, comprising board-certified experts in treating members with SCD, reviews and updates all clinical components of our program under the oversight of Dr. Monte.

Our Sickle Cell Outreach program identified Louisiana members with sickle cell disease and provided trained nurses to conduct outreach phone calls. The purpose of the outreach was to provide education and engage the member with a PCP and provider experienced in treating sickle cell disease or a specialist that can work with the member to properly manage their condition. We completed the outreach June 1, 2014. We contacted 366 members and reached and educated 141 members (39 percent). 50 members received written education and 20 members asked to speak with a case manager and were referred to case management.

Our national clinical quality team is adopting SCD evidence-based guidelines tailored to the needs of our members, based upon the National Institutes of Health (NIH) guidelines (e.g., clinical trials or managing transplants for members with SCD). The team has also developed a pain management process to help SCD members manage their daily pain levels so they are not visiting the ER or being admitted into the hospital.

To address the needs of Bayou Health members with SCD and to tailor our SCD program to the needs of our members, we have analyzed Louisiana claims and other clinical data to provide us with an understanding of the prevalence and location of:

- Members with SCD (refer to below figure)

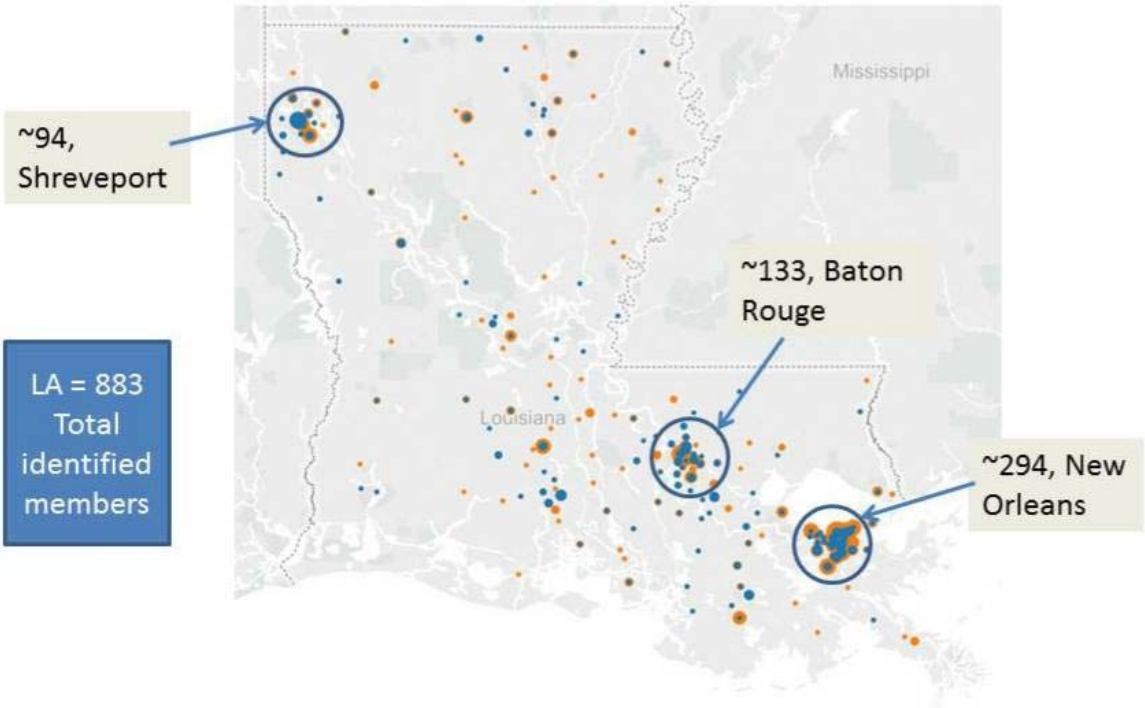


Figure 30. All SCD Members. UnitedHealthcare analysis, Sept. 1, 2012 through Aug. 31, 2013, pulled April 2014; SCD identified using any of the nine diagnosis codes, nine fields, claim $0 paid or greater, 2009 or later.

- Members with SCD who are high utilizers (one or more inpatient admissions or ER visits within a 12 month period) and segmented members by adults and members under 19 (refer to below figure)

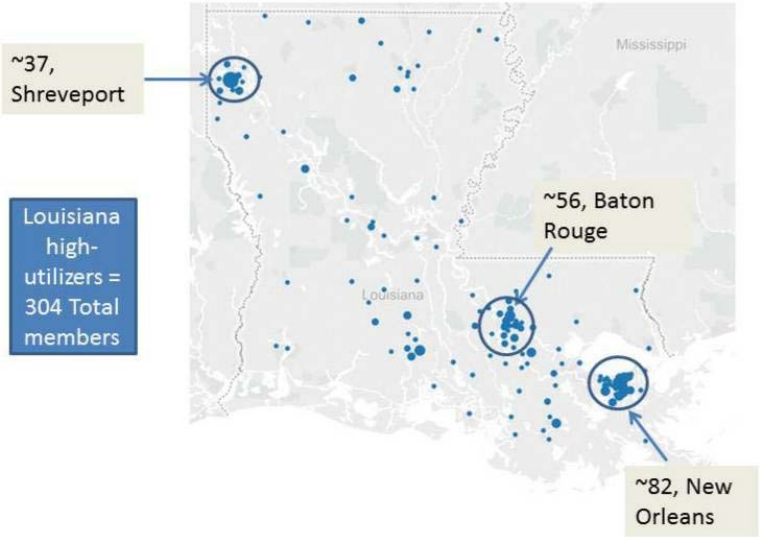


Figure 31. High-Utilizers. High utilizer has more than one ER/inpatient visit (any of nine SCD diagnosis codes) within 12-month study period.

- Providers and specialists with expertise treating members with SCD
- Community resources (e.g., Sickle Cell Disease Association of America chapters throughout Louisiana) that provide support to and advocate on behalf of members with SCD (refer to below figure)

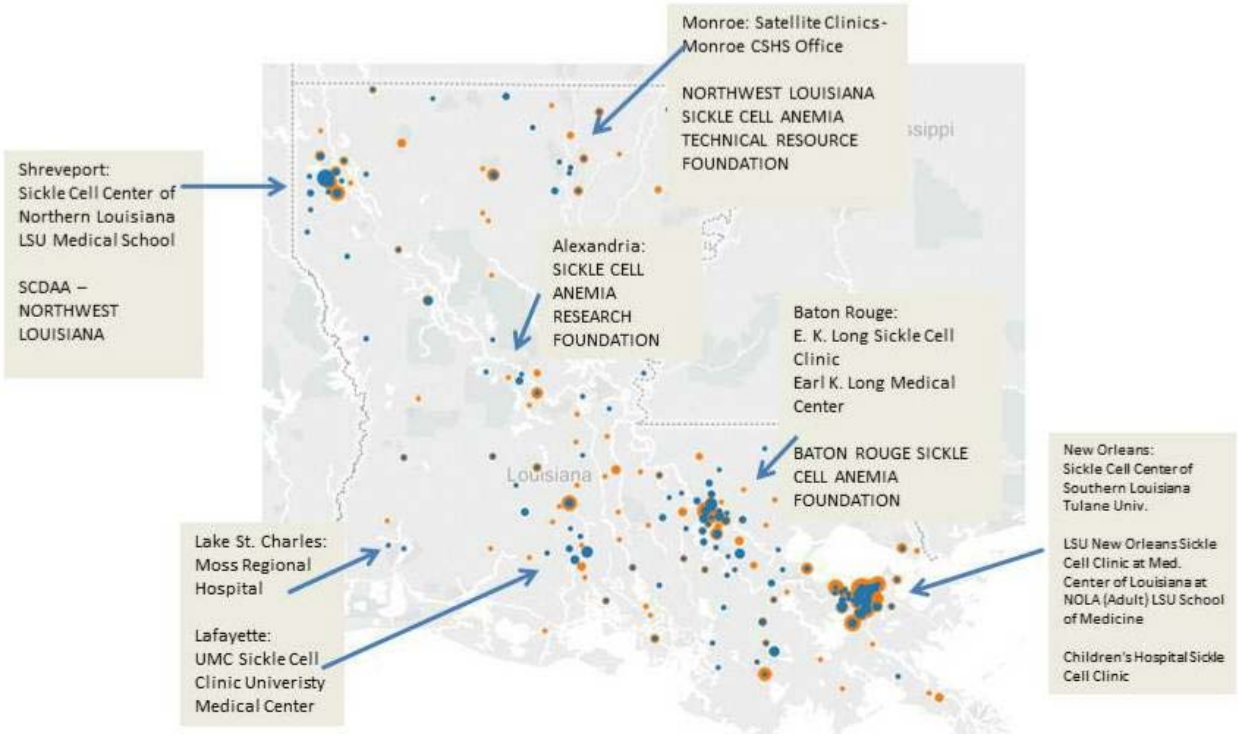


Figure 32. Sickle Cell Support. https://scinfo.org/sickle-cell-clinics-contacts-and-resources#Louisiana.

Using the results of these analyses, we have:

- Developed a case management staffing plan that offers case managers with SCD experience to manage high-risk members with SCD.
- Performed an initial risk stratification of members and identified high utilizers.
- Developed job aids, procedures and processes for SCD case managers.
- Developed referral procedures for SCD case managers to refer high-risk members to specialized programs (e.g., members with behavioral health needs, kidney specialists or transplant specialists). For example, for high-risk pregnant members, the SCD case manager coordinates with the Healthy First Steps case manager to collaboratively manage the member's SCD and their high-risk pregnancy.
- Established relationships with 12 community-based resources (e.g., hospitals, universities and community-based organizations such as the Baton Rouge Sickle Cell Anemia Foundation) throughout the State.
- Established relationships with providers that are affiliated with SCD community organizations, such

Sickle cell program interventions are designed to achieve:

- Early engagement
- Delayed disease progression
- Pain and symptom management
- Prevention of iron overload, stroke, infections, acute chest syndrome, organ failure and other complications
- Identification and treatment of depression

as The Foundation for Sickle Cell Disease Research and to promote a patient-centered medical home.

In addition to these efforts, we are:

- Identifying gaps in our provider network so that we can develop an interconnected network of physicians who are experienced in treating SCD.
- Identifying educational opportunities for PCPs, which includes information on how to manage members with SCD (e.g., use of Hydroxyurea, penicillin and Transcranial Doppler [TCD] screening). PCP education is critical to providing PCPs the knowledge they need to successfully manage the care of members with SCD. For example, TCD screening is a covered benefit that screens for the risk of a stroke. The results of the screening allow the provider to conduct interventions, such as regular blood transfusions, to minimize stroke risk.
- Developing a Louisiana-specific advisory panel that will be made up of non-clinical members, such as community organizations and caregivers, to understand the unique needs of Bayou Health members.
- Working to establish an SCD Center of Excellence in Louisiana, consisting of local providers and specialists with expertise managing members with SCD. This center of excellence will work to improve the care and management of Bayou Health members with SCD.

Once implemented in the State, our Louisiana SCD program will enhance our person-centered model of care by:

- Identifying members with SCD who are at risk for ER use and inpatient admissions (e.g., members experiencing recurring pain crises).
- Engaging high-risk members in case management through collaboration between the member's PCP and a case manager with expertise in managing members with SCD or enrollment in an ACC practice with SCD expertise. For ACC practices without this expertise, our SCD case manager will partner with the ACC practice to manage the member's care.
- Implementing a "feet-on-the-street" model to increase member engagement. Our SCD case manager and community health workers will conduct member engagement-related activities. Partnerships with community-based organizations that support SCD members will help to increase member engagement.
- Engaging providers and members at clinics, hospitals, schools and community events to provide education, develop relationships and connect members to community resources.
- Implementing local, field-based SCD experts, supported by telephonic experts who help find members, conduct the sickle cell assessment, identify

Ongoing sickle cell program interventions include:

- Ongoing evaluation and risk stratification
- Creating, updating, communicating and managing a person-centered plan of care
- Periodic member assessment
- Monitoring and managing ER and inpatient admissions and readmissions
- Coordinating access to appropriate support services both inside and outside of the system
- Member, caregiver, physician education
- Member advocacy throughout all stages of the care continuum

gaps in care and resolve barriers to care, such as transportation).

- Coordinating with behavioral, pharmacy and other services, such as Healthy First Steps.
- Ensuring development of an effective, person-centered plan of care to reduce pain and manage symptoms, including short and long-term goals.
- Ensuring members have a pain management plan to manage their daily pain levels so they are not visiting the ER or admitting themselves into the hospital.
- Providing member/caregiver education and support, such as use of Hydroxyurea; managing daily life functioning; coping with cognitive functioning issues; understanding how to speak with providers; transitioning to adult condition management, including managing their own care; and empowering members to get what they need to manage their condition from their provider.

Prenatal Services and Prematurity Prevention

We provide expectant mothers with information related to prenatal care, nutrition, prematurity prevention and parenting through our innovative programs and community outreach. We offer our case management program to all high-risk pregnant members in our most vulnerable risk category.

- ***Healthy First Steps:*** This is a personalized maternity wellness program that provides members with additional support and education throughout their pregnancy.
- ***Baby Blocks:*** We provide smartphone and online tools available through Baby Blocks program to remind expectant mothers about impending prenatal or postpartum appointments.
- ***Text4Baby:*** Expectant mothers can receive informative and educational texts about pregnancy and child care.
- ***Healthy Baby Showers:*** UnitedHealthcare has been the sole Bayou Health plan sponsor for the March of Dimes Community Healthy Baby Shower initiative. Through this effort, we reach pregnant women, new moms and their support systems to provide them with education and awareness about prenatal and postpartum care.
- ***Educational Initiatives:*** We outreach to teenagers in schools and health fairs to educate about the risks associated with teen pregnancy and premature births.
- ***Outreach Calls – Health Assessments:*** We conduct welcome calls and health assessments, which identify pregnant women. During this call, we provide information to expectant mothers on the necessity of prenatal care and assist with setting up appointments, as requested.
- ***Appointment Reminder Technology:*** Member engagement features are employed by our Automated

OB Health Home Experience

We recently developed OB health homes in Tennessee and Wisconsin. Although these programs are too new to provide data showing improved outcomes, they are showing promise and we are receiving positive feedback. We will use the information gleaned from our community engagement as well as lessons learned from Tennessee and Wisconsin to engage key Louisiana stakeholders, such as OBs; the American Congress of Obstetricians and Gynecologists; the Association of Women's Health, Obstetrics and Neonatal Nurses; and the Louisiana Academy of Family Physicians, to identify opportunities to develop OB health homes.

Care Transitions software, which includes appointment reminders and confirmations after an inpatient stay, e.g., post-delivery.

Program Goals:

- Improve pregnancy outcomes for pregnant women and their babies
- Reduce incidence of low-birth weight births
- Improve access to pregnancy programs that result in improved health outcomes
- Improve the nutritional and psychosocial health status of pregnant, high-risk members
- Increase appropriate use of medical, behavioral and social services
- Increase women's self-sufficiency
- Assist women in developing and maintaining healthy lifestyles during pregnancy and beyond, focusing on smoking cessation and discouraging use of alcohol and other drugs

Measures:

Delivery Outcomes

- Type of delivery
- Percent low birth weight
- Percent of NICU admits

Program Measures

- Number enrolled in case management versus total eligible population
- Number assessed/stratified/reached versus total eligible population
- Trimester enrolled
- Number participating in pregnancy programs, e.g., Healthy First Steps, Baby Blocks, etc.

Members/Populations Targeted for Chronic Disease Management

Population health—focusing on the health of an entire population as opposed to focusing on treating disease states—is a critical element of person-centered care delivery, quality improvement and cost containment. It transcends through the progression of all models of care, inclusive of UnitedHealthcare and state managed programs, patient-centered medical homes (PCMHs) and ACCs.

To support DHH as it seeks to improve the member experience, quality of care and lower costs for individuals and families in Louisiana communities, we are committed to implementing improved ways to identify, care for and support the needs of our Bayou Health general population as well as our most vulnerable member (high-risk cohorts) populations through new models of care. Our most vulnerable members often have care needs spanning across and beyond the health care delivery system. Their needs may include primary and specialty medical care, behavioral health care, substance abuse treatment and community supports (e.g., transportation and housing). Effective case management is essential to ensuring coordination of services across these domains, connecting providers, enabling the exchange of relevant information for treatment of the full range of a member's needs and avoiding adverse medication interactions and duplicative services.

With the goals of improving life satisfaction, improved health status, and decreased ER use and hospitalization, members may be stratified and offered to participate in case management and CCMP if they have a high-risk pregnancy, chronic conditions or complex, comorbid conditions. Case managers provide ongoing condition-specific education, coaching on lifestyle changes, referrals to community-based social supports and review needs for transportation, child care, housing and other issues. Each case manager uses regular contact, health literature, empowerment strategies, motivational interviewing, cultural competency and health literacy strategies to develop a strong relationship with the member to encourage active participation, personal growth and control over their health and wellness. CCMP goals include teaching members self-management techniques.

Case managers work with members to set short-term and long-term goals, prioritize goals and incorporate them into the plan of care. We provide members assistance with any obstacles they encounter but encourage members to overcome them on their own. Self-efficacy is assessed as a critical self-management tool and reinforced, as needed. Getting members to acknowledge their conditions and understand they are in control of their own health is a key accomplishment. We measure success by the closure of care gaps, signaling the member is proactively managing his/her health.

We address multiple modalities to make sure members identified for CCMP receive the appropriate interventions. Two-way interactions focusing on self-management support and health education are achieved by one or more of the following modes: telephonic contact, field visits and mail-based communications requested by the member. Members receive at a minimum: monthly interactive contacts based upon the member's case management needs, but frequency and intensity of two-way contacts may occur daily if needed.

Case managers use a variety of tools and techniques to engage members and move them through the continuum of care. These methods and techniques include:

- Motivational interviewing techniques are foundational to negotiating behavioral changes and assisting members in developing strategies for change based upon person-centric, unique life and health goals.
- Encouraging members to complete tasks linked to achieving goals. We help members develop problem-solving techniques to overcome barriers along the way.
- Teaching members coping skills to help them manage their emotions. This allows referrals to mental health providers, peer support specialists and peer support groups, disease/condition education, community support groups, and provider referrals as needed to reassure members they are not alone. Providers and resource lists are available and accessible electronically to all case managers. Case managers follow up on these referrals to make sure members successfully access them. As part of ongoing monitoring and follow up, case managers routinely remind members about care opportunities, e.g., open gaps in care identified through Impact Pro and Universal Tracking Database (UTD) systems. Following are examples of suggested plan of care elements.

Suggested Plan of Care Elements	
Care gaps/opportunities	Provider care, transportation and pharmacy barriers
Clinical practice guidelines for specific conditions	Basic needs, e.g., stable housing, food assistance or utility assistance
Health and self-management goals	Assessment results
Psychosocial needs, e.g., grief or HIV support	Involvement of guardian, caregiver

Identification of Members Requiring In-Person Case Management

We are implementing programs that provide "high-touch" case management for targeted groups of members, including our most vulnerable members and the top five percent of utilizers. For members who are identified or stratified at the highest risk for poor health outcomes, our case management program can include face-to-face interaction by a nurse case manager with medical or behavioral health experience, as a member's condition requires, a behavioral health coordinator or community health worker. Face-to-face meetings may be used to conduct more in-depth health assessments, develop the individualized plan of care and make changes to the plan over time, as the member's needs change.

Visits by community health workers can be used to help high-risk members locate and connect with valuable local community resources and supports to help members reach their health and wellness goals. Community health workers are available to help these members remove barriers to accessing care by connecting them to PCPs or arranging transportation. Community health workers work closely with our care coordinators, case managers (including Healthy First Steps nurses) and member services staff to support and educate our high-risk members about the benefits of case management and CCMP programs.

We use retrospective and prospective methods to ensure potential high-risk members are identified as early as possible. To identify members who meet criteria for face-to-face case management, we continuously forecast risk through predictive modeling of our claims data. To supplement our retrospective, claims-based approach, we perform an automated HRA. We also review authorization requests, hospital and ER use, pharmacy data and referrals from providers, members and their family/caregivers as well as UnitedHealthcare clinical staff. Individuals identified for possible case management go through a more in-depth, scored comprehensive assessment and are routed to the appropriate case management program and CCMP based upon the outcome of that scoring. The criterion we use to identify members who may require face-to-face case management services includes members with:

- Chronic and/or complex conditions
- Multiple co-morbidities
- Physical and behavioral health conditions
- History of ER usage
- No medical home
- Inpatient admits
- Lack of social support
- Utilization thresholds (SECA, four ER visits or two inpatient stays in a 6-month period)
- Predictive Modeling (Impact Pro) thresholds (greater than10)

Integration with Existing Louisiana Resources and Programs

Community health workers are an important part of our person-centered model. They work closely with our care coordination and case management staff to provide member education and assistance in accessing needed services. Using their knowledge of local resources and Healthify, our database of community resources, community health workers as well as member advocates can link our members to available community resources specific to a member's needs or condition. Community health workers interface with high-risk members face-to-face and telephonically.

The link to community services can have a direct and positive impact on our member's health outcomes. For example, members with diabetes need to replace fast food diets with fresh fruits and vegetables. Community health workers can link members to food bank services, provide details of how to access their regional food bank or mobile panty and when services are available. UnitedHealthcare is in the process of creating a partnership with food banks across Louisiana to address food deserts and access to fresh fruits and vegetables. Prevalent in rural areas, food deserts are areas with high poverty rates, no grocery store access, limited availability of fresh foods, a large number of fast food and convenience stores, and high rates of obesity and diet-related illnesses. We work with the Louisiana Food Bank Association, which partners with Louisiana's five regional food banks.

- Northwest Louisiana Food Bank
- Food Bank of Northeast Louisiana
- Food Bank of Central Louisiana
- Greater Baton Rouge Food Bank
- Second Harvest Food Bank of Greater New Orleans and Acadiana

Our goal is to support programs that provide food services to needy members, families and individuals requiring emergency food service and community support. Our partnership aims to provide solutions to hunger crisis through innovative programs and services provided by food banks across Louisiana. Many regional food banks offer mobile food pantry programs—a traveling food pantry that delivers food directly to individuals and families who live in areas with limited resources and infrastructure to support full-time grocery stores or food bank member agencies.

We have joined with Second Harvest Food Bank in New Orleans to create a pilot mobile pantry program to place community health workers in areas where we have a high concentration of our most vulnerable members. In addition to promoting quality food, the pilot focus will give community health workers an opportunity to locate and engage members who are transient. The New Orleans pilot program will serve as a model for implementation in other Louisiana food banks. In addition to food banks, community health workers connect members to community-based wellness programs, such as:

- JOIN for ME (weight management)
- Diabetes Prevention Programs
- Sesame Workshop Partnership Events
- 4-H Eat4Health Programs
- Louisiana Alliance of Boys & Girls Clubs Programs

Coordination of Information and Services between CCMP and Providers

We will share the plan of care with the member's PCP and other providers and invite physician adjustments to this plan. Plans of care are made available to PCPs via BayouCare, our platform that is used to share data electronically between interdisciplinary care team members, with the member's consent.

Our case management staff engages members and confirms they are assigned a PCP, which may be a specialist, and assists the member if he or she has not yet chosen one or wishes to change providers. Each member is strongly encouraged and steered toward the optimal use of the PCP as the medical home for community-based health and preventive services. Community nurses assigned to ACCs work collaboratively with ACC providers to make sure the members assigned to the panel receive services. They review the Population Registry and meet regularly with provider offices regularly working within their assigned location.

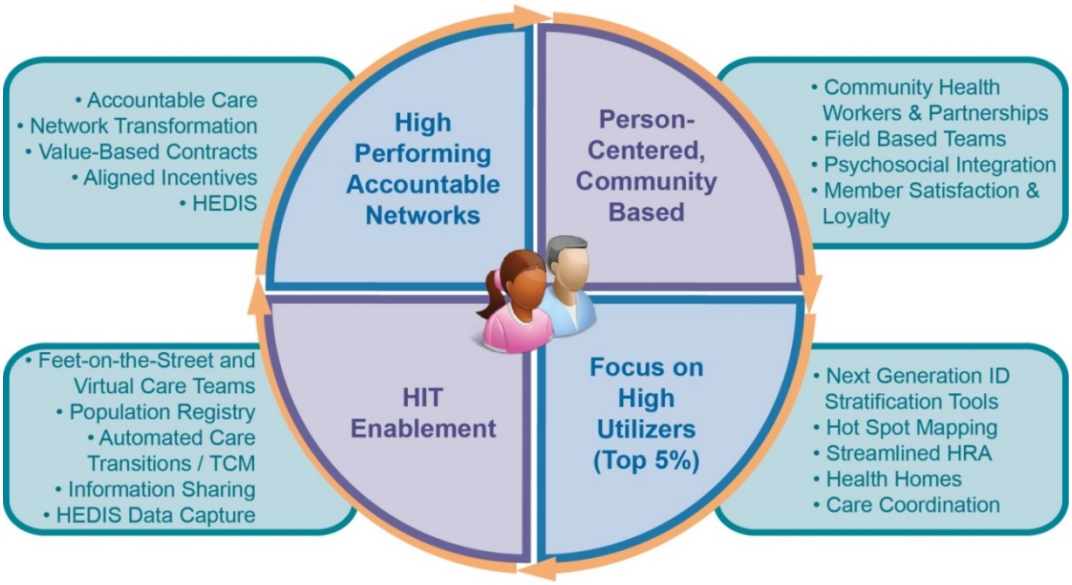


Figure 33. Coordination of Services. We encourage each member to select a medical home for community-based health and preventive services.

We work with our PCPs in several ways to coordinate care with providers:

- ***Provider Outreach:*** Provider outreach helps us engage providers with coordination of care for their new members. The following activities are important to this effort:
  - ***Notification of new members:*** We verify providers receive notification of newly assigned members. We prefer and strongly promote that PCPs access their panel via our secure provider portal, BayouCloud. This offers a better overall experience, allowing providers to use our other site features and reducing the risk of inadvertent protected health information (PHI) release. We send a notification through secure email to all PCPs weekly of their panel reports. This email directs the provider to access BayouCloud to view their current panel. Upon validation and plan approval, automated panel reporting is created on a per PCP, per provider group or per clinic basis. We currently perform this service for our federally qualified health center (FQHC) partners in Louisiana. The provider may also contact Provider Services at any time regarding delivery of a panel report to the provider.

- ***Provider Training:*** We provide PCPs with information about their roles and responsibilities as a PCP, including scheduling an initial appointment with each new member after enrollment. If the PCP's office encounters any difficulty in reaching a new member, the provider office can contact member services for assistance. Providers' and members' contact information is provided to our case management team to assist with outreach and coordination of care.
- ***Information Exchange:*** Providers caring for our members receive reports regarding the health status of our members participating in case management and CCMP. All of our providers with a panel size of more than100 members, including participating ACC PCPs, receive updates on their patients, including notification of ER and inpatient events via the Population Registry. We are the only MCO with an active contract with the Louisiana Health Care Quality Forum (LHCQF), the entity that built and supports the Louisiana Health Information Exchange (LaHIE). We receive admit, discharge transfer (ADT) information from LaHIE and share it with our providers through our Population Registry to improve hospital transitions, assist providers with coordination and continuity of care, and improving health outcomes for our members who transition between care settings, e.g., go to the ER, admitted for an inpatient stay or discharged from a facility. These notifications and alerts improve the timely flow of information so that providers and case managers can quickly and effectively address the health care needs of members transitioning from inpatient facilities to care in the community.

- ***Engaging Providers as Part of Care Team:*** As the link between PCP and member is established, we involve the PCP in the plan of care development process and assist them in directing the course of treatment in accordance with evidence-based clinical guidelines. We engage a member's providers and solicit their feedback on the member's treatment plan and the member's progress toward achieving plan of care goals. We invest substantial effort in establishing and maintaining relationships with the provider community. Demonstrating the value of case management to providers can be key to engagement and can be facilitated by:
  - Seeking provider input and feedback about our case management and CCMP programs during interactions with providers
  - Accepting provider referrals
  - Providing access to clinically valuable member information (with member consent), including pharmacy fills, diagnoses, recent health care service utilization, etc.
- ***Performance Measurement and Accountability:*** By promoting some measure of provider accountability, e.g., shared savings, we can influence a successful case management approach. By linking performance measures with financial incentives, we can align providers and other specialists to support our common goals. Performance measures may go beyond standard HEDIS measures to recognize the complexities of populations. For example, provider incentives could be aligned with quality indicators for member ER use, hospital inpatient discharge data or Louisiana high profile conditions, e.g., SCD.

Methods for Case Management beyond Telephone Management

We are committing to a minimum of 50 percent of program staff in Louisiana by the program operational date of February 1, 2015. Our commitment to provide locally based program staff aligns with our goal to provide high-touch services for our most vulnerable and special needs members who need case management. The following methods facilitate our ability to provide case management services beyond telephone management.

Community Health Workers

Community health workers are locally based staff who provide member education, advocacy and social support and are an important resource for all of our members, particularly our most vulnerable members. Community health workers, through intensive feet-on-the-street efforts, attempt to locate and engage hard to reach high-risk members who are not engaged in medical or behavioral health care or case management. They support the efforts of case managers, behavioral health coordinators and PCPs by working with members to close gaps in care (e.g., preventive health screenings, vaccinations and medications required to manage a condition), educate members about the importance of routine screenings, vaccinations and taking all medications as prescribed and by helping members make provider appointments and arrange transportation. The incorporation of field-based, community health workers to provide supportive services to high utilizing members can improve access to preventive and social services (connect member to YMCA for a weight-loss program) and may lead to reduced resource utilization and cost.

We have a relationship with Tulane University to identify qualified candidates for the role of community health workers. After consultation with and in collaboration with Tulane, this summer we implemented a new pilot for a Person-Centered Care Model (PCCM) in Louisiana. The PCCM pilot focused initially on 100 members in the greater New Orleans area who have been hard to reach and who have not had a PCP visit in the last 12 months. The PCCM pilot included two community health workers who we hired from the local community. First, we stratified members based upon total cost of care and driving diagnosis (e.g., chronic illness or behavioral health). Next, community health workers located and engaged hard to reach these members in their local communities.

Community health workers live and work in the communities they serve. They have expertise in removing barriers to care and can find hard to reach members with the intent to assisting them with PCP appointments and accessing community resources. If a community health worker cannot remove a barrier to care, or if the member has particularly complex and comorbid needs, a nurse case manager provides the extra support the member needs.

Using tools, e.g., Healthify—our database of community resources, case managers, community health workers and member services staff can connect any member who needs assistance to services available in the community. Community health workers may go to community hubs or school-based clinics (an extension of many of our FQHCs) to connect with members “where they are.” When meeting with families, community health workers may inquire about other children who may be living in the home so that we can also link them to needed services, e.g., preventive screenings.

Accountable Care Communities

As part of our population health, person-centered model, we significantly enhance our case management processes by encouraging our members, particularly our most vulnerable members, to join an ACC, our enhanced community-based medical home linking practices to hospitals across the continuum of care, where staff coordinate care; make referrals to covered services, carved-out services and services available in the community; follow up with members; and measure health outcomes. For our ACCs, we offer consulting (community nurses) and technical assistance (transformation consultants) to assist ACC practices with their business transformation.

The ACC model emphasizes face-to-face case management activities through the ACC. Community health workers may assist ACCs by to locating high-risk members. As an example, with a high-risk member with asthma (based upon claims and pharmacy data) who could not be reached by phone, the ACC may request a community health worker who lives and works in the same community to locate and engage the member. Once the member is engaged, ACC staff can follow up and offer an in-home assessment to determine member's environmental risk factors related to asthma.

Through practice selection criteria, we contract with qualifying ACCs to provide care and all interactive population health interventions according to our ACC requirements. We monitor ACCs to ensure that all population health interactive interventions occur, including face-to-face support for health behavior changes, e.g., smoking cessation and weight loss. ACC audit results are maintained and provided to DHH for inspection upon request. We routinely educate ACCs about population health intervention requirements. Our community nurses and transformation consultants communicate with practices about population health-required interventions. Through data contained in CareOne, BayouCare, Impact Pro and the Population Registry, we determine if members assigned to an ACC are receiving all required interactive interventions from the practice as well as non-interactive interventions provided by UnitedHealthcare.

Specific ACC practice supports provided by transformation consultants and community nurses include:

- ***Transformation consultants*** are locally based and are assigned to specific ACC practices and assist in each practice's development as a medical home. Using practice-specific and claims-based data, transformation consultants monitor each ACC practice's performance on a regular basis and provide formal performance updates to each practice. In addition, transformation consultants complete clinical and workflow assessments to ensure that all population health interactive interventions occur, including face-to-face support for healthy behavior changes (e.g., smoking cessation and weight loss).
- ***Community nurses*** are locally based and are assigned to specific ACC practices and collaborate with ACC practice case managers to review members' risk factors, preventive tests, services and physician-recommended interventions and then follow up with external referrals to confirm the member is following those recommendations. Community nurses and transformation consultants routinely educate ACC practices about population health intervention requirements and any member changes noted by community nurses.

Pre-existing Community Organizations and Community Hubs

Brad Grundmeyer, member services manager, oversees most of our community outreach programs. For example, today we successfully engage with Health Centers in Schools (HCS), the organization that supports school-based clinics in East Baton Rouge Parish. We collaborated with HCS to conduct a health fair at Broadmoor High School in February 2014. Throughout the day, more than 350 students attended the fair during their physical education classes. Together with HCS, we promoted the importance of adolescent well child visits and screenings for sexually transmitted infections. Other participants at the fair included Pennington Research Center, institutions offering educational programs for careers in health care and Trader Joe's, a retailer that provided healthy snacks for the students. In April 2014, UnitedHealthcare was a sponsor for the annual Louisiana School-Based Health Alliance conference. In addition, our quality director spoke on school-based health centers (SBHC) collaboration with the Bayou Health plans at the conference.

We provide EPSDT-specific educational materials to members. Brochures are disseminated at community events, schools and provider offices. Some examples include:

- Check-ups are Important
- Keep Your Health in Check: Healthy Checkups
- Managing your Weight
- Tips on Talking with your Doctor
- Emergency Room Diversion Flyer: Where to Go to Get Well

Member Engagement Techniques

Member engagement is an integral part of our CCMP. In Louisiana, we engage our members participating in CCMP via in-person outreach through community health workers and case management, staff participation in community events, telephonic outreach and through text or Web-based information, e.g., via *liveandworkwell.com*.

We encourage members to use the following mobile apps:

- ***Online HRA:*** We are working to make the HRA available to members online via *myuhc.com* and mobile devices. Providing the HRA via mobile devices offers members an additional choice for how members engage with us. Pew Research Center research shows adults with low household income at 43 percent smartphone ownership with 18 to 29 years of age having 77 percent smartphone ownership.
- ***liveandworkwell.com:*** Healthy living and other educational topics are provided to members on through *liveandworkwell.com*. After logging into *myuhc.com*, users can link to *liveandworkwell.com* and select

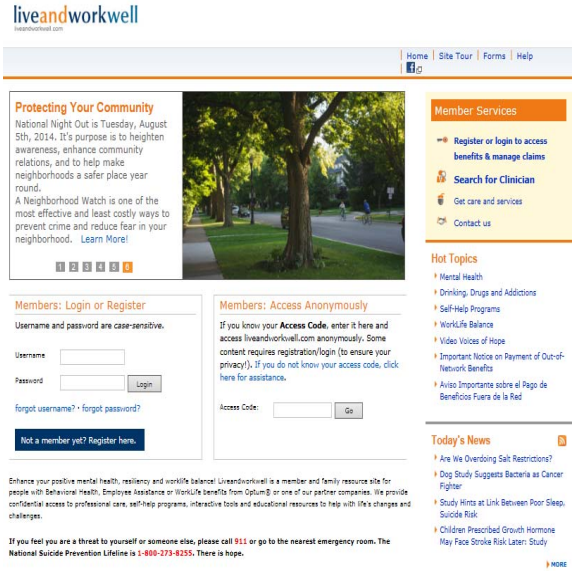


Figure 34. Through liveandworkwell.com, an on-line service site, members can do personalized research and request referrals for a variety of services.

topics such as work/life balance, weight loss and updated health news items.

- ***Public Website:*** We provide a public website, *uhccommunityplan.com*, which provides the public with plan information such as enrollment, benefits, eligibility, finding a provider, important links to health information, etc. This website provides members with the ability to choose English or change the language to Spanish or Vietnamese.
- ***Member Portal:*** We maintain a secure member portal available only to members through the website, *myuhc.com*, to provide information such as telephone contact information, the *Member Handbook*, a searchable list of providers, health care services history, benefits and coverage information, member rights and responsibilities, information on how to file grievances and appeals, etc.
- ***Text4Baby:*** We provide the Text4Baby service to connect with expectant mothers and new moms. Through this service, we send out educational text messages with information on pregnancy and child care.
- ***Baby Blocks:*** The Baby Blocks program uses smartphone and online tools to remind, incentivize and encourage pregnant women to attend their prenatal, post-partum and well-baby appointments.
- ***Twitter:*** Social media users can connect with us through Twitter to obtain educational tips and health care information.

Baby Blocks

Our Baby Blocks Web-based application was awarded the Medicaid Health Plans of America 2013 **Best Practice Award** for Technology.

- ***Health4Me:*** The free Health4Me mobile application enables mobile users to review health benefits, access claims information, locate in-network providers and contact information, etc.
- ***Smart Patient:*** We provide mobile users with the free Smart Patient application. This allows mobile device users to track important information, such as blood pressure, record appointments, record doctors' orders, view educational videos, etc.
- ***OptumizeMe:*** The free OptumizeMe mobile application allows users to set health and fitness goals, challenge other users to set their own goals and post the results on Facebook.
- ***DocGPS:*** We provide mobile users with the free DocGPS mobile application. This enables mobile device users to search our provider network and obtain travel directions to a provider's location.
- ***KidsHealth®:*** Our online KidsHealth program includes resources that are provided to assist high-risk members with managing their conditions, such as diabetes, asthma and stress, and adopting a healthy lifestyle. Videos, written and spoken articles are provided to children, teens and their parents, who can engage with this program through a link on our public website, *uhccommunityplan.com*, and can be accessed through a computer, tablet or smartphone.
- ***Automated Care Transitions (UHCTransitions):*** We support comprehensive transitional care and follow-up for members moving from one setting to another, particularly those leaving an inpatient facility and moving back to a community setting. Our Automated Care Transitions software has member engagement features, including member reminders, appointment confirmations and reminders to take medications.

Engaging Bayou Health Members through Education

Case managers use a variety of tools to customize a member's educational needs. They have access to a member's ER visits, hospitalization, basic behavioral health needs and specialty behavioral health case management, when the state management organization (SMO) provides this information to us. We can create a dashboard with gaps in care to provide the case manager with the member's HEDIS gaps in care for preventive, wellness and chronic disease management. Case managers interact with members to provide customized education and support the educational materials we provide in member mailings. Case managers also help members use our secure member portal, *myuhc.com*, which provides additional education, such as program eligibility.

The CCMP relies on two-way interactions focusing on self-management support and health education. The interactions are achieved by telephonic contact (includes text messaging), field visits or mail-based, disease-specific communications requested by the member. The member's interdisciplinary care team includes case managers, providers, members, family members and other community partners in the case management process as a way to more fully understand the member's needs. Case managers emphasize the importance of medication adherence and evidence-based disease management education. The member and case manager may review the educational materials together either by phone or in person. In these discussions, we teach members symptom management and what to do if their symptoms worsen or their condition changes. Care coordinators, case managers or community health workers may participate in meetings with a provider and member either by phone or in person to help support the member's condition management and monitoring and to help remove barriers to accessing care. Our goal is to hire community health workers with specific expertise, e.g., maternity, particularly in Louisiana's rural areas, e.g., northern Louisiana, where accessing services can be more challenging.

Figure 35. Targeted Education for Members. We customize educational programs to a member's needs.

Diabetes Prevention and Control Alliance
UnitedHealthcare offers a variety of solutions to support people with diabetes and pre-diabetes. The Diabetes Prevention and Control Alliance (DPCA) is a partnership with UnitedHealthcare and the YMCA. The Diabetes Prevention Program, which addresses the link between diabetes and obesity, revealed that lifestyle changes and a 5 percent weight loss can prevent or delay the onset of the disease by 58 percent.

Chronic Care/Disease-Specific Education

Case managers provide chronic care/disease-specific education to members for all comorbidities, based upon identification of the member's needs through population health risk

stratification. For example, for a member with CHF, disease-specific education seeks to reduce unnecessary hospitalizations and health care costs and works to improve the health of the member. The CHF education program provides information, interventions, community health workers to help remove barriers to care and other resources to help members, including:

- Managing CHF through daily monitoring of key findings, including weight and symptom changes or symptom-specific management
- Adhering to physician treatment plans and drug therapy regimens
- Managing risk factors and co-morbidities, including high blood pressure, asthma, diabetes, CAD, COPD and depression
- Understanding CHF and how to receive the most clinically appropriate, cost-effective and timely diagnostics and procedures

Our clinically integrated health system focuses on a holistic care experience with a focus on care transition, care advocacy and chronic disease management, to address the full spectrum of care for providers and members.

We provide initial education, including program information, to members during our welcome call and the case manager's first contact with the member. We provide disease-specific education to members for each co-morbid condition, based upon identification of the member's needs through assessments and telephonic outreach and face-to-face visits, as necessary.

Member Self-Management Education

Our comprehensive health education program considers the member's whole health care needs. We assure high-quality education services supported by evidence-based guidelines and effectively promote self-management education through multiple modes and activities. Case managers are an integral part of the health education program and facilitate coordination, continuity and appropriateness of services to meet our members' health care needs.

Figure 36. Educational Materials. Educational materials promote healthy habits and self-management.

- ***Chronic disease management materials*** are sent to newly identified members diagnosed with chronic conditions, such as asthma, diabetes and CHF, with telephonic follow up conducted by a RN to perform an additional assessment and provide further disease management support.
- ***Prevention and Wellness Education Program*** is an outreach program serving Louisiana Medicaid/CHIP members, providing preventive health and screening services. We support and collaborate with a wide array of screening events to promote health and bring awareness on the importance of keeping our members' health in check. Since the implementation of the Bayou Health program, our outreach team has engaged in or hosted more than 150 health screening events and health fairs, reaching approximately 43,000 Louisiana residents.

- ***Telephonic outreach calls*** includes preprogrammed telephonic messages in English and Spanish and are made to members identified as needing specific preventive services. Depending on the member's status and needs, the messages are tailored as educational, general reminders or specific reminders.
- ***Live outreach calls*** are especially used for those members who are noncompliant with their recommended preventive screenings or live in a region near an upcoming community wellness event.
- ***Educational brochures***, such as those listed below, are provided by the quality management and marketing department and disseminated at community events, schools and provider offices and during outreach events:
  - *Check-ups are Important* (targets children, ages 3 to 6)
  - *Have you had your Check-up?* (targets adolescent/teen well-child visits)
  - *Keep Your Health in Check: Healthy Checkups for Adults* (targets adults)
  - *Happy Birthday! Things to do on your birthday* (adjacent image, targets all ages)
  - *Be wise….Immunize* (targets children, birth to adolescent)
  - *Managing your Weight* Pocket Slider (targets general wellness)
- Our flu campaign is an outreach to members to encourage them to schedule flu shot vaccinations.

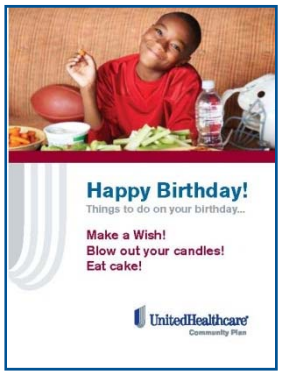


Figure 37. Happy Birthday Educational Brochure. This brochure targets all ages.

- Our Hospitality, Assessment and Reminder Center (HARC) make welcome calls to new members as an introduction to the health plan. This call begins with an HRA for each member and will serve as the basis for person-centered activities, including self-management education.
- *HealthTalk* is a quarterly newsletter mailed to all Louisiana members.
- Marketing team members, health services members or clinical practice consultants attend statewide health fairs to provide education literature on children's immunization, diabetes, steps to stay healthy – annual checkup, eye exam, dental visit, immunizations.
- Text4Baby, a free text-messaging program, offers information throughout pregnancy and, after delivery, information related to the postpartum period and infant care until the first birthday and Baby Blocks, a reminder system that engages pregnant women during their pregnancy and in the first 15 months after delivery.

We offer an innovative clinical model focusing on person-centered solutions. The model stratifies member populations using multiple data points to customize the approach to best meet a person's unique needs, including cultural and linguistic preferences. It uses a variety of resources and includes real-time data-sharing across the care continuum to reduce costs and improve outcomes. Through the use of local interdisciplinary teams, we engage members with high utilization and their providers and caregivers to positively impact members' lives through caring engagement, education and compassion. This engagement ultimately reduces unwarranted emergency room visits and admissions and improves the connection and relationships between members and their PCPs.

Person-Centered, Integrated Model of Care and Case Management

Our person-centered model provides an integrated system of care coordination and case management while supporting cost-effective, quality care and maintaining a holistic focus on the member. Our population health model helps us achieve Triple Aim of better health outcomes, improving the care experience and lowering the cost of care for Bayou Health members, especially our most vulnerable members. At the state level, population health provides a deeper understanding of each member's needs not just those who have a disease and high costs.

Our most vulnerable members may move between population health-based chronic disease management activities to a more intensive level of case management and CCMP over time as their needs, preferences and the severity of their conditions change. Members who are identified as general (well) or at-risk accelerate almost two times faster to acute/complex status than complex chronic members who descend to lower cost status. Complex chronic populations that are not well managed or compliant with their care typically represent 5 to 7 percent of a total population. Population health helps slow the progression of complex chronic management and the related costs associated with these individuals by:

- Keeping healthy members healthy
- Intervening early with members at-risk and progressing toward more complex care
- Ensuring complex chronic members get the care they need when they need it

Because members are at the center of our model of care, they have a greater capacity to proactively improve their quality of life and their medical and behavioral health outcomes. We reduce costs by providing person-centered care in the most appropriate and cost-effective setting and by decreasing avoidable hospitalizations and ER utilization. We conduct early identification of at-risk members identifying emerging needs through an early warning system.

Regardless of changes in intensity, the member's case manager remains the same, whenever possible, so that a strong relationship between the member and the nurse develops and remains intact. Case managers address the needs of members using standard condition-specific, evidence-based guidelines, addressing multiple chronic conditions through a single integrated approach. The goal is to empower individuals, in collaboration with physicians and other health care professionals to effectively manage chronic conditions, associated risk factors and co-morbidities. Assessing member health risk is a critical process in our model of care. Community health workers and ACC are important parts of our person-centered model, case management program and CCMP.

Types of Personnel Providing Case Management

Our person-centered model of care and our case management and chronic case management programs tap a unique combination of capabilities to help our members navigate the health care system in achieving health and well-being goals. Our approach focuses on complex care needs through a whole-person wellness perspective. We are fully committed to medical and behavioral integration, and assign our most vulnerable members to a case manager with medical or behavioral expertise.

Our case management services are primarily performed by case managers who are often licensed RNs, including managers, with a medical or behavioral expertise or by care coordinators, including behavioral health coordinators, or community health workers. In general, these

professionals have a minimum of three to five years of experience. They are supported by chief medical officer Dr. Ann Kay Logarbo and an interdisciplinary care team, which may include PCPs, social workers, pharmacists, other providers, etc. Administrative staff supports all functions in the program.

Case Managers: Collaborating with interdisciplinary care team members, case managers serve as the designated accountable point of contact for each member's person-centered plan of care. Case managers have a medical or behavioral expertise and typically are RNs, licensed social workers or behavioral health professionals. All case managers receive training on interdisciplinary case management and key case manager responsibilities. The case manager works with the interdisciplinary care team to implement the plan of care. Case managers have an integral role in successfully maintaining members in the least restrictive environment by employing the skills of the interdisciplinary care team members in the ongoing management of the member.

Community Nurse: This field-based, RN staff is in place locally and meets face-to-face with ACC providers and high-risk members assigned to ACCs. Community nurses live within the same practice community, are assigned to specific ACC practices and collaborate with ACC practice case managers to review members' risk factors, preventive tests, services and physician-recommended interventions and then follow up with external referrals to confirm the member is following those recommendations. Community nurses and transformation consultants routinely educate ACC practices about population health intervention requirements and any member changes noted by community nurses.

Community Health Workers: Community health workers are an important part of our person-centered model. They work closely with our care coordination and case management staff to locate and engage high-risk members, to provide member education and assistance in accessing needed services (remove barriers), to ensure timely access to providers and to help our members navigate the health care delivery system, whether the services are covered or not or if the needed services are provided by the member's PCP or a specialty provider from another health plan. Using their knowledge of local resources and Healthify, our database of community resources, community health workers and member advocates link our members to available community resources specific to a member's needs, working face-to-face in the local community or telephonically with our members.

Behavioral Health Coordinators: We currently have three locally based behavioral health coordinators who work directly with members, our case management team and the SMO. They serve as an essential link between our members and their health care providers by providing collaboration of medical, mental health and substance abuse care resources, escalating members to the SMO as necessary. They collaborate with case managers and adhere to formal processes when they coordinate with members and network and non-network providers, make referrals; follow up with members, providers and SMO; and closely monitor the interventions and services for members receiving specialty behavioral health.

Figure 38. Behavioral Health Coordinators. We currently have three locally based behavioral health coordinators who work directly with members, our case management team and the SMO.

This local staff regularly participates in weekly integrated medical and behavioral health rounds, which also include participation from Dr. Logarbo, medical management manager Linda Rintala, the manager of Healthy First Steps case management, the utilization manager if needed, the SMO's chief medical officer and other clinical representation from the SMO. Our behavioral health medical director will attend all joint rounds as well. An average of 10 cases is presented weekly during joint rounds, inclusive of referrals to and from UnitedHealthcare to the SMO. In addition, we have attended behavioral health summits with the SMO along with other health plan staff and providers. We regularly hold meetings with FQHCs to assure coordination of services between medical services and basic and specialty behavioral health services.

Chronic Care Management Program Policies and Procedures

In accordance with RFP section 6.39.4, we will submit our CCMP policies and procedures to DHH for approval within 30 days of contract signing, annually and prior to any revisions. CCMP policies and procedures will include all of the elements required in RFP section 6.39.4. In addition, we agree to comply with each specification and requirement outlined in RFP sections 6.39 Chronic Care Management Program (CCMP), 6.40 Predictive Modeling and 6.41 CCMP Required Reporting.

Part V: Benefits and Member Management

Section P: Non-Emergency Medical Transportation

P.1 Describe in detail your proposed approach to providing non-emergency medical transportation (NEMT) services, including, at a minimum:

- What administrative functions, if any, you will subcontract to another entity (If subcontracting this function, the subcontractor information must be provided in response to item F.4);
- How you will determine the appropriate mode of transportation (other than fixed route) for a member;
- Your proposed approach to covering fixed route transportation;
- How you will ensure that pick-up and delivery standards are met by NEMT providers, including training, monitoring, and sanctions;
- How you will ensure that vehicles (initially and on an ongoing basis) meet vehicle standards, including inspections and other monitoring;
- Your approach to initial and ongoing driver training;
- How you will ensure that drivers meet initial and ongoing driver standards;
- How your call center will comply with the requirements specific to NEMT calls; and
- Your NEMT quality assurance program (excluding vehicle inspection). (10 points)

We recognize the importance of providing culturally competent non-emergency medical transportation (NEMT) benefits for Bayou Health members to support their ability to self-manage their care and to sustain important relationships with their PCPs, OB/GYNs and other providers. We are sensitive to the fact that members with special health care needs may require additional care and customized support based upon their physical need (e.g., wheelchair assistance) or cognitive ability (e.g., autism spectrum disorder). For this reason, we are using our Medicaid-experienced transportation provider, LogistiCare. LogistiCare is a subcontractor with extensive NEMT experience statewide.

We have included the required subcontractor information in our response to item F.4 for LogistiCare, This response also describes, in detail, our vendor oversight policies and procedures.

We monitor performance standards to ensure that members receive timely and quality NEMT services and impose performance penalties and corrective action plans should we identify performance issues. We routinely survey members as part of our member satisfaction process to track and trend issues with NEMT performance. We look nationally for innovation – like smartphone app technology or Fast Pass Vouchers for members in need of emergency transportation – and determine their usefulness to our Bayou Health membership.

Deb Tillman, provider claims educator, brings 15 years of experience and her specific understanding of the state of Louisiana to her management of LogistiCare. LogistiCare has provided NEMT brokerage programs for Bayou Health members for the past three years—including management of the current transportation program for all members across the three MCOs participating in the LA pre-paid program—and has a fully operational, comprehensive NEMT network of providers within the state.

LogistiCare has 66 transportation contracts with UnitedHealthcare in 35 states and the District of Columbia and brings solid experience to the Bayou Health NEMT program.

Proposed Approach to NEMT Services

Our proposed approach to meeting the needs of Bayou Health members supports their access to care in a safe, convenient way and encourages and promotes healthy behaviors. We have the experience and the infrastructure in place to "make good health happen" for members using:

- Our proven delegated subcontractor, LogistiCare
- LogistiCare's established NEMT network in Louisiana
- Compliance with Bayou Health contract requirements
- Membership communication efforts about the NEMT benefit
- Leadership oversight of NEMT performance
- Established performance standards and reporting mechanisms

Administrative Functions Subcontracted

As a valued and experience subcontractor, LogistiCare will assume all day-to-day administration of our NEMT program, including:

- Call center operations
- Scheduling
- Assigning and dispatching trips
- Determining the appropriate mode of transportation
- Verifying appointments and member eligibility
- Providing manifests to transportation providers
- Conducting vehicle inspections
- Collecting and reporting to us any member or provider complaints

Determining Appropriate Mode of Member Transportation

Providing appropriate transportation for members is critical to member safety and satisfaction. We use a combination of member self-reporting and clinical assessment to determine the appropriate mode of transportation for members using the following approach:

- ***New Member Welcome Call:*** We identify the needs of members and their families within 14 days after receiving the notification of new member enrollment from DHH. We conduct a new member welcome call and initial health risk assessment (HRA) to identify members with special health care and transportation needs. Per Section 6.19.2, we assess those members identified as having special health needs within 90 days of identification.
- ***Case Management Assessment and Care Coordination:*** We assign a case manager who assists in planning and coordinating care for a member with special health care needs, as identified by the enrollment file or indicated during the initial assessment. Case managers assess members using the comprehensive health status assessment **(**CHSA) and other disease-specific assessments. The assessment evaluates the member's cognitive and decision-making skills, motor planning (e.g., ability to plan physical movement) and functioning, memory and need for assistive devices or accommodations (e.g., wheelchair,

oxygen). The assessment is a critical component of the member's plan of care to identify individual needs related to transportation. This includes:

- Current health status
- Cognitive functioning
- Level of independence
- Physical functioning or needs (e.g., wheelchair, stretcher, car seat)
- Unique behaviors/fears that may cause injury or self-harm

- ***Member Preference and Self-Determination:*** The case manager discusses the recommended transport options with the members and their caregivers and recommends the safest, most appropriate transportation methods based upon their current level of functioning and each member's preference. Every effort is made to assess which methods of transportation will best accommodate the member's needs while still providing for the least restrictive, most comfortable method of transportation.
- ***Member Reassessment:*** As a member's needs change, the member's case manager will continue to assess needs, coordinate care and determine member preference. It is a reiterative process. LogistiCare is also an important link in evaluating a member's transportation need during the initial intake call with the member. This process is described below.

The Role of the LogistiCare Customer Service Representative

The role of the LogistiCare customer service representative (CSR) is to make sure the member is offered the most appropriate mode of transportation according to the member's mental or physical condition, while also considering the preference of the member and the most appropriate transportation modality (e.g., transit bus, van).

Typically, a member will arrange transportation through their case manager or through our UnitedHealthcare member service line the first time. After the member is familiar with the process, the member can call LogistiCare directly at any time to arrange transportation. The system automatically displays the member's requirements history during the trip reservation process, ensuring that the individual's needs are communicated properly to the call agent, provider and driver. Their consultative assistance also includes:

- ***Identifying the Level of Need:*** LogistiCare's CSR uses a customized call script (approved by the State) to verify member eligibility, ascertain level of need, document the date and time of covered service appointment, and verify trip origination and provider site destination information. CSRs are trained to identify special passenger requirements. These special needs might include:
  - Physical assistance or the need for an escort, due to age (e.g., a minor) or disability. We also require a minor child who has a covered services appointment to be accompanied by an adult member.
  - Pickup from a shelter location. For individuals who may be homeless or living in a shelter, we acquire a detailed description of their physical residence during our first interaction with them. We ask for specific instructions for locating their place of residence and adapt our records for these members who may change living situations frequently. Our files may include a hand-drawn map as needed to assist with locating the residence, especially in rural areas where there may not be street addresses. This

detailed location of residence will be stored in the member's clinical record and the hand-drawn map is scanned and stored electronically in the record. These documents can be uploaded and sent securely to NEMT providers or other providers as needed for the purpose of care coordination.

- ***Trip Confirmation:*** The CSR documents member answers in the transportation system. Once all information is entered, the CSR confirms trip specifics and provides a confirmation number. Then the CSR electronically routes the trip request.
- ***Covered Services and NEMT Eligibility:*** CSRs ask questions to make sure members are using transportation services only for covered services (including carved-out services), supporting our fraud, waste and abuse detection efforts. Once member eligibility is verified, additional questions guide the CSR and the automated system to select the most appropriate mode of transportation and level of service (e.g., curb-to-curb, door-to-door or hand-to-hand service).
- ***Recurrent Appointments:*** If the member has a standing order (e.g., recurrent appointment), we make every effort to select the same transportation provider for the member's prescheduled trips.

Members can request NEMT services by calling the member services center toll-free number on their member ID card. Instructions for requesting transportation will also be included in the *Member Handbook* and provided to members during their first welcome call.

Approach to Covering Fixed Route Transportation

Non-emergency medical transportation services will be provided through a variety of transportation modes. This service mix will include fixed route offerings, basic vehicles, enhanced vehicles, non-emergency ambulance transport and other transportation methods as needed.

Fixed route transportation will be provided according to the specifications of the State. We can stipulate the appropriate distance from a bus stop from where a member lives or could be dropped off. During the reservation process, call representatives will determine the proximity of a member to a bus stop and then will assess the member's ability to get to the stop, and his or her comfort level with doing so. The member's concerns will be heard and addressed through this process to ensure that the member feels safe and able to get to the stop and manage the public transportation option. If appropriate, family members or caregivers will be included in the discussion and decision-making process. Upon determination of the appropriate need, LogistiCare will distribute bus passes to the member through the mail.

Ensuring pickup and delivery standards are met by NEMT providers

Our primary concern when scheduling any type of transportation for members, wherever they reside, is safety and appropriateness. This includes our ability to provide necessary transport services to homeless or transient members of the community who need essential care coordination or access to primary care. Because our member transport program relies so heavily on our understanding of the communities we serve in rural, frontier and tribal areas of the State, we use this knowledge to provide a wide range of transportation alternatives that are culturally appropriate for members. We **ensure that pickup and delivery standards are met** through the use of extensive driver training, monitoring, sanctions and other program monitoring.

Driver Training

All NEMT drivers receive at least 32 hours of initial training from LogistiCare prior to providing transportation services. Drivers also receive an additional 15 hours of training annually to refresh their skills. All training is documented, and all training documents are retained in each employee's file. Employee files are reviewed during onsite audits to confirm clean driving records, background checks and vehicle safety. The table below illustrates the comprehensive training curriculum required for each LogistiCare driver.

Training	Topic	Training Hours
Initial Classroom Orientation	▪ Credentials Re-check ▪ Review of Louisiana geography and local culture ▪ Review of policies and procedures ▪ Training in basic first aid and CPR ▪ Accident and emergency protocols ▪ Passenger assistance ▪ Seasonal inclement weather procedures ▪ Review of policies and procedures for handling biohazard and spill usage kits ▪ Review of applicable HIPAA requirements and confidentiality of member health records ▪ Enhanced understanding of mental health issues ▪ Services available in the community ▪ How to help when someone is experiencing symptoms of a health care emergency ▪ Successful completion of LogistiCare Provider/Driver Training Certification: • National Safety Council Defensive Driving Course • National Safety Council first Aid/CPR/AED Course • The Community Transportation Association of American, Passenger Assistance Sensitivity and Safety (PASS) Basic	32 hours
Day One	Full day of job shadowing with current NEMT driver	
Day Two **Day Three**	Two days of on-the-job training with an experienced driver who provides evaluation and coaching	
Ongoing Training (Annual)	Review of initial training topics (with any current updates); refresh on best practices	15 Hours

Driver Monitoring

We monitor transport services through the use of LogistiCare's online reporting website. This website provides comprehensive reports and analyses on any component of the transportation programs used by Bayou Health members, such as:

- ***Summary report:*** Enrollment, trip volume, excessive mileage, denials, utilization, trip modes, member services statistics including feedback from members
- ***Standard trip reports:*** Cancellations, on-time performance, trip counts, etc.

- ***Standard compliance reports:*** Critical driver and vehicle data prior to each assignment
- ***Standard complaint reports:*** Investigated, resolved or escalated complaints
- ***Member services center reports:*** Average hold time, average speed of answer, percent of calls abandoned, etc.
- ***Provider Report Cards:*** Monthly assessment of performance quality based upon key performance indicators such as complaints or on-time arrival

Driver Sanctions

LogistiCare has developed and fine-tuned several mechanisms to monitor compliance with all aspects of performance and adherence to contractual standards related to driver safety and sanctions. We require that all Louisiana drivers meet the State of Louisiana's standards for NEMT approval. We audit the State's list of approved providers and maintain copies of these records. We also check all transportation providers, owners thereof or drivers, as applicable, against the following:

- ***Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) database:*** This database provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all federal health care programs.
- ***National Sex Offender Registry:*** This public website—coordinated by the Department of Justice—enables every citizen to search the latest information from all 50 states, the District of Columbia, Puerto Rico, Guam and numerous federal installations (e.g., Native American tribes) for the identity and location of known sex offenders.
- ***Excluded Parties List System (EPLS):*** This is an electronic, web-based system that identifies those parties excluded from receiving federal contracts, subcontracts and certain types of federal financial and non-financial assistance and benefits. The EPLS keeps its user community aware of administrative and statutory exclusions across the entire government expanse, including individuals barred from entering the United States.

Other driver documentation that is submitted in hard copy format for review and retention includes:

- Driver's name, date of birth and Social Security number
- Copy of the driver's license
- Driving record for previous three years as obtained from state police
- Current training certificates
- Background check
- Drug/alcohol screen results
- Complaints received about the driver and any accidents or moving violations

Other Program Monitoring

To verify the licensing of every driver and the safety of every member, LogistiCare routinely performs the following safety checks – a combination of automated data review and on-site person to person observation – that includes:

- ***Automated Safety Notifications:*** Each month, a list of upcoming expirations for a variety of compliance items (e.g., driver's license expirations and annual Motor Vehicle Records

[MVRs]) are sent to every provider as a reminder of the requirement to maintain contract compliance. If the requested information is not received, the provider may receive a reduction in trips, be assessed liquidated damages or be removed from the network until all information is received.

- ***Expired License Reporting:*** LogistiCare managers run the expired driver's license report every month to identify drivers with upcoming license expirations. Letters are sent out to remind providers that they need to submit renewal documentation. The letter also advises them that if the required documentation is not received by LogistiCare by a certain deadline set prior to the impending expiration, the driver will be rendered inactive.
- ***On-site Inspection:*** LogistiCare staff conducts visits to transportation provider's operational locations to review their files for required qualification documents. This is done in addition to the requirement to send in documentation. LogistiCare may also check records for provider compliance with state and federal laws, regulations and permit requirements. By following this process, LogistiCare can verify or reject drivers and vehicles. LogistiCare employs strict initial credentialing standards and uses a rolling verification process to verify provider documentation and to maintain compliance with the terms of the contract.
- ***Surprise Field Visits:*** LogistiCare field monitors regularly conduct unannounced visits to transportation pickup and drop-off locations to observe and record driver compliance with operational and customer service standards. The monitor may inspect vehicles for required documents and equipment, in addition to observing drivers' behavior. Driver behaviors of all kinds are tracked through the complaints and field investigation processes. These behavioral observations allow us to record driver compliance with operational and customer service standards, including courtesy to members.
- ***Operation Clean Sweep:*** LogistiCare brings various staff and managers together in the field to monitor transportation providers at different pickup and drop-off locations over an unannounced period of time (several days). This method allows us to check multiple providers simultaneously with the purpose of confirming driver and vehicle compliance with program requirements.

Ensuring Vehicles Meet Vehicle Standards

As part of the initial credentialing process, all vehicles are required to pass inspection based upon the schedule required by the state. Inspections are conducted to confirm vehicle integrity and that safety requirements are met as listed within the Transportation Provider Agreement between transportation providers and LogistiCare.

LogistiCare field monitors verify that vehicle safety inspections are conducted and each vehicle is issued an appropriate sticker noting the status of the inspection. The sticker is placed on the inside of the lower left front windshield for easy member identification.

If a vehicle fails inspection, we deactivate the vehicle in our system and the owner is informed they cannot use the vehicle for LogistiCare trips. If any attempt is made to use the vehicle for trips prior to re-inspection and approval, they will not be paid for the trips and they are subject to liquidated damages and corrective action.

We require the following vehicle documentation in hard copy format for review and retention to verify safety standards:

- Manufacturer, make and model year
- Vehicle identification number
- Odometer reading at the time the vehicle entered service under a LogistiCare contract
- Type of vehicle (e.g., wheelchair van)
- Capacity (number of passengers)
- License plate numbers
- Insurance certifications
- Copy of state issued registration permit and vehicle stamp (if applicable)
- Special equipment (e.g., lift, ramp)

Initial and Ongoing Driver Training

As part of the training effort, we will train new and existing transportation providers in the geography of Louisiana, the culture and the correct pronunciation of cities, towns and family names in compliance with Section 4.6.3. We are sensitive to the fact that members with special health care needs may require additional care and customized support based upon their physical need (e.g., wheelchair assistance) or cognitive ability (e.g., autism spectrum disorder). Our ability to communicate with them in a familiar, respectful manner that provides a safe, comfortable environment during their ride is our primary concern.

We use a calculated combination of oversight, training, monitoring, inspections and performance metrics to make sure NEMT providers are meeting our stringent standards for quality and contract compliance. For example, LogistiCare requires that all drivers are fully trained before ever getting behind the wheel to transport a NEMT member. LogistiCare has implemented a Provider/Driver Training Program that is unique in the NEMT industry because it calls for all drivers to successfully complete three training programs created by nationally accredited institutions (or similarly accredited courses). The three accredited classes encompass the following:

- ***National Safety Council Defensive Driving Course (NSCDDC):*** The training includes instruction in defensive driving strategies and techniques to reduce the chance of collision; how drugs, alcohol, physical conditions and emotions affect driving decisions; how to deal with driver distractions and fatigue; and the importance of occupant safety devices and how to use them.
- ***National Safety Council first Aid/CPR/Automated External Defibrillator (AED) Course:*** This program is designed to teach the lay-person basic First Aid and CPR including how to handle: bleeding and wound care; shock from burns; serious injuries to bones, joints and muscles; sudden illness during transport; emergencies due to extreme cold or heat; and blood borne pathogens. Additionally, drivers are trained on the protocols for using an AED and how to administer CPR when responding to breathing and cardiac emergencies in adults, children and infants. This program meets or exceeds all Occupational Safety and Health Administration and Industrial First Aid and CPR standards.
- ***The Community Transportation Association of American, Passenger Assistance Sensitivity and Safety (PASS) Basic:*** This program is designed to provide community transportation drivers with current expertise in passenger assistance techniques and

sensitivity skills appropriate for serving persons with disabilities. Drivers who transport passengers who use a mobility device, such as a wheelchair, scooter, or Segway are required to take an additional three-hour "hands-on" class.

- ***Mobility Device Safety (PASS Hands-on):*** This hands-on class lasts approximately three hours and teaches the following:
  - Mobility device securement systems
  - Lift operating procedures
  - Mobility device and occupant safety techniques

Ensuring Drivers Meet Initial and Ongoing Driver Standards

We use a variety of tactics to ensure that drivers are meeting initial and ongoing standards including: monitoring performance standards, ongoing training and random audits.

To provide exceptional NEMT performance in Louisiana, our LogistiCare contract contains several performance standards to monitor the quality of services provided to members. We monitor these metrics routinely and, if we identify a deficiency, will place our vendor on a corrective action plan and may institute financial penalties for continued issue, and ultimately terminate the contract if the issues are not rectified. We convey our expectation that transportation brokers do an annual refresh of their processes and technology to maintain performance expectations. Brokers that do not meet the level of our contractual requirements are placed on corrective action plans and may not be invited to work with Bayou Health members and their families.

Monitoring relies on a combination of metrics based upon usage, on-site observation and member feedback from our NEMT providers. Quarterly, we meet with LogistiCare's leadership to review transportation metrics and make necessary adjustments to enhance the quality of their service. We ensure compliance to program requirements through ongoing (monthly, quarterly, annual) oversight and periodic audits. We require all of our NEMT providers to meet the performance standards in accordance with the Bayou Health program requirements. Our dedicated, local transportation coordinator performs scheduled and unannounced quarterly NEMT audits. These audits include random validation checks, review of driver trip logs and incident reports, analysis of statistical reporting of trips and review of other relevant information. They analyze member complaints and member satisfaction surveys to identify potential problems and to determine frequency and potential trends. We will strengthen compliance through performance contracting. Call Center Compliance with Requirements Specific to NEMT Calls

Members can request NEMT services by calling the member services center toll-free number on their member ID card. Instructions for requesting transportation will also be included in the *Member Handbook* and during their first welcome call. Members have two options during their call:

- ***Direct Connection:*** Members will have the option to choose the "transportation" option when they call the toll-free 800 number for member services (printed on the reverse side of their member ID card.) They will be auto-routed to LogistiCare with no need to be transferred. Members can also call the LogistiCare customer service center directly.
- ***Assisted Connection:*** For those members who require additional support, they can call our member services center and request to speak to a UnitedHealthcare member services

representative (MSR) who will warm conference a three-way call with LogistiCare to confirm the member's transportation is arranged. If the member requires any NEMT follow-up, the MSR takes responsibility and helps resolve it for the member. Conversely, if a Bayou Health Member contacts LogistiCare directly with a problem or issue, LogistiCare will warm conference a three-way call with our member services center. The MSR will identify, own and help resolve the issue for the member.

NEMT Quality Assurance Program

Ms. Tillman provides oversight of LogistiCare NEMT services to assure compliance with all NEMT-related program requirements, including compliance with Bayou Health guidelines. She will provide leadership and oversight of the NEMT program to achieve high-quality service and continuous quality assurance and improvement for Bayou Health transportation services.

NEMT Continuous Quality Assurance and Improvement

Our Quality Assurance Program for NEMT uses regular performance assessment tools, such as our scorecard, to document and monitor key performance indicators. It also serves as an effective communication tool to support efforts toward continuous quality improvement. For example, the transportation scorecard below will be modified to meet DHH requirements and will be used during monthly governance calls with LogistiCare. Any deficiency found in the quality of our transportation providers is addressed immediately, and corrective action is taken by meeting with the provider to discuss the incident or deficiency and measures to resolve any identified problems.

Sample Transportation Scorecard

SAMPLE TRANSPORTATION VENDOR

For each category, a total of 20 points can be earned. See "Status" column below for point scoring key. A total of 10 points can be earned.

Key Measure/ Indicator	Description	Status	Score	Detail and Source Document
Trip Timeliness	At least 30 but no more than 60 mins before appointment, no more than 60 min wait time, confirm 24 hrs before trip, documen trip cancellations, notify member of unavoidable delays	Green - Yes - 20 Points Yellow - In Part - 10 Point Red - No - 0 Points	20	**Measure:** Timeliness reports **Location:**
Call Center Metrics	abandonment rate no greater than 5%, at least 75% of calls answered within 45 seconds,	Green - Yes - 20 Points Yellow - In Part - 10 Point Red - No - 0 Points	20	**Measure:** Call Center Reports **Source:**
Licensure Verification	Verification of new transportation providers, listing of providers terminated, suspended, or restricted	Green - Yes - 20 Points Yellow - In Part - 10 Point Red - No - 0 Points	20	**Measure:** Subcontractor Networking Report **Location:**
Complaints and Grievances	Utilization management and quality management reports; respond to grievances in less than 10 days	Green - Yes - 20 Points Yellow - In Part - 10 Point Red - No - 0 Points	10	**Measure:** Grievance System Reports **Source Document Location:**
Particular issue(s) or concerns		Green - Yes - 20 Points Yellow - In Part - 10 Point Red - No - 0 Points	10	**Measure:** VRO and delegated entity lead identify high risk issues **Source Document Location:**
Total		**out of 100 points**	80	

Scoring Key		Overall Scoring Key	
Green	20 points	Green	80 - 100 points
Yellow	10 points	Yellow	60 - 79 points
Red	0 points	Red	59 points or less

Maintaining close collaboration with NEMT providers ensures that they understand performance expectations, and will result in achievement of high transportation quality. For providers that are challenged with meeting requirements, strategies such as reducing trip loads are often employed to help them improve the quality of services provided. While providers are operating under reduced-trip circumstances, education and support is provided to further drive quality improvement with the goal to gradually increase to larger trip loads and eventually return to normal service. Should a problem with a transportation provider escalate beyond this level of training and cooperation, further restrictions are enforced, and we reserve the right to terminate any transportation provider as needs and circumstances dictate.

As part of our continuous quality assurance efforts we are actively engaged with our NEMT managers in ways to improve our services to members. As we continue to look for ways to enhance the delivery of NEMT services, we look for ways to improve local efforts by leveraging our national best practices such as those listed below.

New/Innovative Strategies	Overview
Fast Pass	A program that reduces non-emergent ER utilization by redirecting members to primary care. Fast Pass is an option available to our clinical staff or ACC/PCMH partners for members who have immediate needs, a history of ER utilization above thresholds, or that have other circumstances as determined by a clinician, care coordinator or authorized person performing member outreach. For these members, we will offer scheduled point-to-point transportation to a primary care appointment. Fast Pass will be tested with our ACC/PCMH partners, case managers and field staff starting with frequent ER users. These members will be interviewed and evaluated for Fast Pass eligibility; those who qualify will be flagged in the NEMT manager's system. The Fast Pass Program will work as follows: ▪ Our staff will engage with high risk members, in person, to improve their care coordination. Our service coordinators will, through the assessment process and in collaboration with their managers, determine if a member has sufficient transportation challenges to merit having access to the Fast Pass service. ▪ Once a member is determined to be an eligible candidate, service coordinators educate the member about Fast Pass and how to use it. ▪ The manager communicates to transportation subcontractor the member authorization for Fast Pass and approved provider destinations. A member, provider or our staff may arrange a Fast Pass trip. Pickup is available with an expectation of less than one hour but within a maximum of two hours of a transportation request. The transportation provider will wait for the member during the appointment and then transport the member back to his/her home.
Cross Boundary Coordination	Cross boundary coordination will be used to reduce the duplication of effort occurring when one vehicle could transport multiple members from various MCOs to coordinated facilities/locations for care rather than having multiple vehicles at the same location for the different MCOs. Cross boundary coordination can be used for intermediate stops and transfers to expedite transportation, especially in urban areas where we can leverage fixed route methods of transportation or provide transfer stations to other vans to reduce costs and improve efficiency. With DHH approval, we will engage other MCOs and our transportation brokers in discussions to further this initiative.

New/Innovative Strategies	Overview
Integrated Medical and Transportation Appointment Scheduling	We are creating a plan with LogistiCare to better coordinate standing appointments and requests from providers or members. Additionally, this program will allow medical providers to schedule transportation on behalf of the member. Alternatively, the member may call the transportation broker and the transportation broker schedules the medical appointment on their behalf. Our transportation subcontractor has integrated processes used by dialysis clinics, nursing homes and BH clinics to jump-start this program. This plan is scheduled for mid-2015.
New Technology	We keep abreast of potential new technology having an impact on NEMT services (e.g., secure online scheduling to reduce administrative burden; requests via the smartphone applications that benefit members, e.g., Curb). We will work with DHH for approval to implement innovations for our members and providers.

Exceeding Service Standards

All transportation providers must meet or exceed criteria for orientation, inspection, credentialing, evaluation, testing and contracting. Compliance components also include recruitment, extensive background checks and orientation training of qualified sub-contract drivers. Orientation helps assure that drivers are trained on performance requirements, standards of conduct, vehicle standards, insurance requirements and record-keeping requirements that include detailed daily trip logs. This is followed by a hands-on, diligent approach to managing the entire network of sub-contracted providers. A combination of oversight, field inspections, monitoring provider performance and transportation standards, and training will be used to make sure transportation providers are meeting stringent standards for quality and contract compliance and confirm that pickup and delivery standards are met. Each provider agreement will contain a set of contract requirements for NEMT services, including compliance with the Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation. Vehicles will also comply with program requirements as specified by DHH, and all applicable federal, state, parish or local requirements.

Supervision of NEMT providers will be conducted through:

- Member or provider complaint monitoring
- Feedback from clinical services and provider advocate teams
- Member and provider advisory committee meetings
- Field inspections
- Monthly driver scorecard results

All NEMT providers' vehicles and communication equipment will be inspected prior to February 1, 2015 and at least every six months thereafter. NEMT providers will be required to maintain all vehicles and equipment to meet or exceed local, state and federal requirements, and manufacturer's safety, mechanical, operating and maintenance standards. In the event that deficiencies are identified, the vehicle will be removed from service until corrective action can be undertaken, completed and verified.

Additional Key Components of our Approach to NEMT

Established NEMT Network in Louisiana

LogistiCare has provided NEMT brokerage programs for Bayou Health members for the past three years—including management of the current transportation program for all members across

the three MCOs participating in the LA pre-paid program—and has a fully operational, comprehensive NEMT network of providers within the state.

As a current provider serving more than 427,000 Bayou Health members across all three MCOs, LogistiCare has the experience and ability to communicate with Bayou Health members in a familiar, respectful manner that provides a comfortable environment during a member's request for services. As part of this effort, LogistiCare provides initial and ongoing training for new and existing transportation providers to familiarize them with the geography of Louisiana, the culture and the correct pronunciation of cities, towns and family names in compliance with Section 4.6.3.

Use of Proven Delegated Subcontractors

UnitedHealthcare uses a small number of tested and reliable partners and affiliates with whom we have a strong track record of working together to deliver high quality products and services. LogistiCare is one of these trusted partners. Although we delegate functions to them, we maintain complete accountability for performance and systematically oversee all delegated relationships through our Louisiana leadership team. Every aspect of service delivery is designed to be in compliance with specific State contractual requirements, and all regulations that apply from state and federal laws.

Compliance with Bayou Health Contract Requirements

To meet the needs of DHH and our Bayou Health members, we agree to meet or exceed each specification and requirement outlined in Section 7.8.9. (Non-Emergency Medical Transportation) and Bayou Health Guidelines. In addition, we agree to provide transportation services as a core benefit, as specified in Sections 6.0 (Core Benefits and Services), 6.36, (Care Transition) and 9.7 (Emergency Services) and 6.14.1.8 (Family Planning). We will also provide all necessary NEMT services for any carved out benefits, including dental and behavioral health services. These requirements will be conveyed in the LogistiCare contract

Member Communication Efforts

As part of our extensive experience with coordinated care implementations and ongoing operations, we understand that non-emergent transportation is a critical aspect of covered services for members. All Bayou Health members will receive information on obtaining emergency and non-emergency medical transportation through the *Member Handbook*, the welcome newsletter and the welcome call, in compliance with Section 12.11 and 12.12. In addition, every member will be able to access NEMT services through the toll free 800-number for member services located on their member ID card.

Leadership Oversight of NEMT Performance

Ms. Tillman will provide stringent monitoring of the services provided by LogistiCare through multiple channels that rely on a combination of metrics based upon usage, on-site observation and member feedback from LogistiCare. We have complete oversight of the transportation programs that we provide, including member satisfaction. The LogistiCare member services center reporting generates nearly 250 standard reports that allow us to measure and analyze performance on a daily, weekly, monthly or annual basis. We also have the flexibility to produce any type of operational, management or ad hoc report that might be useful in examining and strengthening our procedures and program outcomes. Our daily, monthly and quarterly monitoring process encompasses:

- ***Daily online dashboard reporting:*** Through the use of LogistiCare's NEMT operations website, we have access 24 hours a day, seven days a week to an online reporting website that allows us to review and maintain complete records of all program activities to document that the operations adhere to all applicable State requirements and regulations.
- ***Monthly performance reporting:*** The results of the daily NEMT dashboard reporting are consolidated into a monthly report for management review. We monitor critical data and variances, mileage reimbursement and summary trip reports in an effort to proactively address any changes in timeliness and quality of the member's experience. Through critical incident reporting and quality of care feedback, our quality department tracks transportation concerns, including lack of access, for immediate follow-up.
- ***Quarterly leadership oversight:*** We monitor timeliness and overall adequacy through multiple channels including a quarterly meeting with LogistiCare leadership to review transportation metrics and make any adjustments that validate the quality of our NEMT services to members.

If a member has a complaint or grievance, they can report it to their case manager or our member services team. We make certain that LogistiCare meets the complaint and grievance system requirements as specified in Section 13.4.

NEMT Performance Standards and Reporting

To provide exceptional NEMT performance in Louisiana that meets or exceeds requirements, our LogistiCare contract contains several performance standards that are designed to ensure our members are receiving high quality service. We monitor these performance metrics routinely and if we identify a deficiency, will place our vendor on a corrective action plan and may institute financial penalties for continued issues, and ultimately terminate the contract if the issues are not rectified. Our performance standards include:

- ***On-time Arrival:*** Member on-time drop off at least 95 percent of the time
- ***NEMT Provider Satisfaction:*** Member satisfaction with providers at least 95 percent and member complaints per completed trip shall be less than or equal to 1 percent per quarter
- ***Complaint Resolution:*** Resolution of member complaints will be acknowledged within 24 hours and resolved within 72 hours
- ***Timely Encounter Claims:***100 percent of all encounter claims will be submitted within 90 days of the date of service and 98 percent of all encounter claims will be received as clean claims
- ***Timely Average Speed of Answer (ASA):*** Calls answered within an average of 30 seconds or less; call abandonment rate no more than an average of 5 percent and an average hold time of less than three minutes.
- ***Provider and Transport Availability:*** LogistiCare will maintain or exceed an acceptable number of participating network providers to adequately serve Bayou Health members and assure that an appropriate number and types of vehicles are available to assist Bayou Health members (e.g., wheelchair van, car, public transport)

NEMT Reporting

Through LogistiCare, we have access to the LogistiCAD system, a proprietary software system that is designed to integrate all the functions of safe, member transportation programs. Its unique client/server and web-based functionality provides us with immediate oversight of NEMT

operations using a built-in predictive algorithm. This enables us to spot and track trends, identifying potential issues that can affect members. These types of issues can range from a car broken down in traffic to the threat of a natural disaster (e.g., hurricane, flooding) that may affect a member's pickup or drop-off time. At all points of member transport, we monitor these occurrences; communicate with the member or their family; and work to create a safe, pleasant member experience. The LogistiCAD system has several capabilities, including:

- Taking reservations
- Analyzing traffic patterns to suggest the best route
- Alerting customer service representative to driver delays
- Managing call center operations
- Verifying member eligibility
- Tracking compliance with contract requirements
- Documenting passenger concerns
- Assigning and dispatching service work to assure passenger safety

NEMT Provider Report Cards

LogistiCare's local director of operations meets face-to-face with each provider quarterly to discuss report card ratings and the provider's standing compared to other providers in the program. This program has proven effective in keeping our providers aware of their performance and stresses the fundamentals of service to our members. We have provided a sample of a transportation provider report card.

Transportation Provider Report Card*			
Transportation Provider:	ABC Transportation		
Period of Time:	June 2014		
Key Performance Indicators	**Provider's Actual**	**Standard**	**Score***
1. Valid PLs, PNSs, PPs and INJs against the provider as percent of the provider's total gross trips	0.00%	0.10%	15
2. Ratio: Complaint percent to gross volume percent	-	1.0 or less	15
3. Cancellation percentage	12.0%	15%	8
4. Percent of trips dropped off at the "A" leg destination on time or within 15 minutes of on time	98%	95%	13
5. Percent of gross trips rerouted	2.5%	2% or less	9
6. Percent of gross trips upgraded	0.00%	0.70%	15
7. Are provider's drivers, vehicles and insurance in compliance? Response: Yes or No	Yes	Yes	10
		Score	**85 out of 100**

** Range: 0=Needs much improvement to 15=Greatly exceeds standards*

The results of our statistical analyses, trending reports and performance provide DHH and our operations team with valuable insights into program functionality so we can make informed decisions about immediate needs and future improvements based upon the needs and preferences of members.

Veteran/Hudson Initiative

We recognize the importance of using local small and veteran owned businesses in Louisiana. Therefore our LogistiCare contract for transportation services includes an incentive to contract with transportation providers who are Veteran/Hudson Initiative certified for the entire 36 months of the contract. We have set targets for the number of Veteran/Hudson certified providers and the amount of revenue expended with these providers for LogistiCare as described in the table below.

[redacted]	
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Section Q: Pharmacy

Q.1 Identify your current or proposed PBM, specifying any corporate relationship to the bidder. (If subcontracting this function, the subcontractor information must be provided in response to item **F.4**) (1 point)

We will assume responsibility for all prescription drug services as found in Section 17.10.5. Our national Medicaid pharmacy management team will manage the pharmacy benefit for Bayou Health members while our affiliate, OptumRx, Inc. will serve as our pharmacy benefits manager (PBM). Particularly relevant is OptumRx's experience providing Medicaid PBM services for UnitedHealthcare in twenty states since 2001. As the country's largest PBM, OptumRx has a deep understanding of the unique requirements of the Medicaid managed care business and has proven to be an effective partner.

Our pharmacy benefit management partner, OptumRx has provided innovative PBM services for more than 20 years. Through their extensive experience serving diverse populations, OptumRx has developed a sophisticated array of high-quality, integrated PBM services, including retail pharmacy network claims processing, specialty pharmaceutical management and clinical programs. By focusing on clinical quality and total patient care, they help members improve health outcomes while managing overall health care costs. Today, they manage benefits for nearly 13 million consumers and process more than 370 million claims per year, representing approximately $25 billion in managed drug spend.

Our chief medical officer, Ann Kay Logarbo, M.D., will have complete oversight of our pharmacy management team and the pharmacy services to members enrolled in the Bayou Health program.

We have included the required subcontractor information in our response to Section F.4 for OptumRx, This response also describes, in detail, our vendor oversight policies and procedures.

Q.2 Describe the MCOs flexibility to customize PBM policies and procedures to meet Louisiana specific needs and program goals. (5 points)

We have reviewed the State's requirements and agree to customize our policies and procedures to meet Louisiana specific needs and program goals as referenced in the table below.

RFP Contract Section	Scope of Work
4.6	Staff Training and Meeting Attendance
5.13	Copays/Cost Share
5.14	Financial Disclosures for Pharmacy Services
6.3	Pharmacy Services
6.14	Family Planning Services
6.30	Continuity of Care for Pregnant Women
6.33	Continuity of Care for Pharmacy Services
6.35	Pharmaceutical and Therapeutics (P&T) Committee
7.3	Geographic Access Requirements
7.15	Pharmacy Network Requirements
8.6	Service Authorization Pharmacy Services
8.7	Step Therapy or Fail First Protocols

RFP Contract Section	Scope of Work
8.8	Medication Therapy Management
8.9	Lock-In (Restriction) Program
8.10	Pharmacy Administrative Simplification
8.14	Drug Utilization Review (DUR) Program
9.5	Claims Processing Requirements
12.13	Member Identification Cards
12.18	Oral Interpretation and Written Translation Services
12.20	Pharmacy-Related Marketing and Member Education
14.0	Quality Management
16.1	General Requirements
16.13	Records Retention
17.2	Claims Processing
17.10	Pharmacy Claims Processing
18.10	Pharmacy Reporting: We will submit all drug encounters, with the exception of inpatient hospital drug encounters to DHH pursuant to the requirements of Section 17.10.3 of this contract. We understand DHH or its vendor shall submit these encounters for federal supplemental pharmacy rebates from manufacturers under the authority of the DHH Secretary pursuant to Section 2501 of the Patient Protection and Affordable Care Act (PPACA).
25.11	Debarment/Suspension/Exclusion

Developing Customized State Programs

Our programs will be tailored to meet specific Bayou Health program requirements. As a demonstration of our ability to develop customized state programs, we develop a prescription drug list (PDL) in conjunction with a state's Pharmacy & Therapeutics (P&T) Committee in the majority of Medicaid markets that we serve. The PDL assures the latest in clinically appropriate, evidence-based therapies are made available to members. These states leverage our capabilities related to medical and clinical expertise, assessment of most current clinical practices and deployment of evidence based protocols.

We have also worked with several states to successfully implement a common Medicaid PDL. The approaches are varied so our experience is extensive in this aspect of PDL management. For example: In one market, we worked collaboratively with six other MCOs to establish a core list of common medications. (See box below.)

Ohio: A Common Preferred Drug List

One of our most successfully operated common PDL approaches is for Ohio Medicaid. The Ohio Medicaid program has a very unique process to develop and maintain their PDL. The six MCOs in Ohio are given the ability to independently review new drugs and formulations and conduct ongoing reviews of the PDL to identify clinically appropriate cost savings initiatives through their own P&T committees. All final recommended changes to the PDL must be presented to the Ohio Medicaid program for final approval. To operationalize this approach, each MCO shares the outcomes of new drug reviews and any PDL modification requests from their P&T meetings on a quarterly basis. Decisions and desired changes are incorporated on a single document that serves as the master list of decisions. The goal of this approach is to measure alignment of each PDL. Because each MCO's PDL is within a certain percentage of each other, this maximizes administrative simplification and ease of provider prescribing, which then enhances member access to care. Currently, the Ohio MCOs align with approximately 76 percent of the medications on the PDL.

We are confident in our ability to develop a common PDL in collaboration with the other Bayou Health MCOs and with facilitation by DHH. As an active member of the Louisiana Association of Health Plans (LAHP), we have already initiated discussions with their chief executive officer, Jeff Drozda, to develop ways the LAHP can serve as a convener of the MCOs to facilitate this collaboration. We also welcome the participation of a practicing Louisiana physician on our P&T committee.

Louisiana: Administrative Lock-In Program

We understand our role in combating the problem of prescription drug abuse in Louisiana through treatment programs, but more importantly, through our programs to proactively identify and manage members who are at risk for prescription drug abuse. The integration of the behavioral and physical pharmacy benefit will give us a complete picture of each member's drug utilization pattern that, when combined with our programs listed below, will give us the tools to assume this proactive role.

We support an administrative lock-in program that acknowledges the potential harm to a member who misuses prescription medication and allows us to limit a member to one pharmacy, PCP or both. Our objective is to provide care coordination for members who misuse prescription drugs and other health care services. Our program complies with federal law and regulations, is operational in multiple other states and will be tailored to meet specific Bayou Health program requirements. In our existing Bayou Health contract, we work closely with the DHH Pharmacy team led by Ms. Wendt to administer the lock-in program. We will build on that experience to ensure our lock-in program meets the needs of members, providers and DHH.

Bayou Health Lock-in History

DHH developed the lock-in program to educate recipients who may be misusing program benefits and to ensure that program funds are used to provide optimum health services for recipients. Medicaid recipients who use pharmacy benefits in a manner that medical professionals consider unsafe or inappropriate may be recommended to be enrolled in the lock-in program. DHH created two types of lock-ins:

- Physician and pharmacy lock-in enrollment, where the recipient will be allowed one PCP and specialist if needed, and a single pharmacy provider

- Pharmacy-only lock-in, where the recipient chooses only one pharmacy provider to fill all of his/her prescriptions

In the past, we enrolled recipients in the physician and pharmacy lock-in program or the pharmacy-only lock-in program. With the advent of managed care and primary care linkages, physician lock-in affiliations were dissolved for managed care patients; however pharmacy lock-in restrictions remained in place.

Reviews of pre- and post-utilization patterns of lock-in recipients' drug profiles indicated that **pharmacy-only lock-in does not impact prescription utilization to the same extent as physician and pharmacy lock-in.** When both are in place, we noticed a decrease in ER visits and pharmacy utilization. Therefore, we enhanced our lock-in program, using an RN case manager to outreach and engage both the PCP and the member in the lock-in program.

Current Lock-in Process

Our administrative lock-in program is applicable for members who demonstrate persistent non-compliance, exhibit abusive or threatening conduct, are committing fraud and abuse of medical benefits or have been validated to be overusing services.

Identifying Members for Lock-In Assignment

Currently, members are identified through the DHH Pharmacy Drug Utilization Committee. These members are referred to case management to reach out to both the member and the PCP on record. The profile is sent to the PCP so they can see the historic utilization of medications/pharmacies and other providers. Alternatively, we have the opportunity to report suspects to DHH. We identify members who are potentially committing fraud or abuse in two primary ways: reported tips and data analytics.

Reported Tips: Tips about potential fraudulent member behaviors come through our member and provider services centers or from UnitedHealthcare employees. Member and provider services representatives receive training on how to identify the types of behaviors that warrant a lock-in assignment.

Data Analytics: We also use a variety of state-of-the-art data analytic tools to detect fraud, waste and abuse. Data analysis is particularly effective in identifying member card-sharing (as a means of illegally obtaining services for multiple individuals or as an indicator of identity theft) and suspected member over-utilization. Data analytics can identify members who, during a six-month period:

- Filled prescriptions at more than three pharmacies or saw three physicians in the same specialty
- Obtained prescriptions from several different doctors or have documented evidence of early prescription fills and refills
- Persistently refused to follow prescribed treatments or comply with our requirements
- Engaged in abusive or threatening conduct
- Excessively used physician, hospital, ER or prescriptions not medically indicated
- Engaged in doctor- and pharmacy-hopping

- Allegedly altered a prescription or shared an identification (ID) card with other individuals to obtain prescriptions and other services
- Was referred by our care coordination staff

We will work with DHH to develop other agreed-upon criteria for the identification of potential lock-in candidates.

Review Process of Identified Members for Potential Lock-In Assignment

Working with DHH for the past three years, we identified and initiated member outreach, intervention and case management related to the lock-in program. Identified member cases are referred to one of our high-risk care coordinators for review and determination of appropriate interventions, which may include educational outreach, continued monitoring, possible administrative lock-in, or referral for substance use disorder (SUD) treatment.

Member Notification of Lock-in Assignment

Currently, DHH provides all written communication to identified members. DHH also provides the list of members they have determined require lock-in. The RN case management staff reaches out to the PCP and the member to discuss the lock-in program and the member has a right to appeal their lock-in assignment to the State pharmacist. We also send a written notice alerting a member that he or she will be locked-in to a particular pharmacy, a PCP or both. This written notification informs the member about the:

- Action we intend to take
- Reasons for this action
- Instructions for the member to choose a primary pharmacy or physician as their only source for obtaining prescribed drugs
- Member's right to file an appeal to us or rights to file for a State Fair Hearing
- Effective date of the lock-in, which is at least 30 days after the date of the letter
- Other requirements under federal and state laws and regulations

Follow-Up Review and State Reporting

Once the lock-in assignment occurs, we will perform utilization reviews of the member's paid pharmacy and health care services to determine if the member meets the criteria for an extended lock-in. A member's administrative lock-in does not apply to emergency services. As required, when members are affirmatively identified for lock-in programs and when a member in administrative lock-in transfers to fee-for-service or to another health plan, we will notify the State or the receiving health plan immediately (or at a frequency determined by DHH).

Pharmacy Lock-in Outcomes

As a result of the current pharmacy lock-in program, we have engaged the following members and providers in improving effective use of medication within Louisiana:

# Members	Intervention Results
152	Members referred from DHH for pharmacy lock-in
63	Active in case management
30	Pending initial outreach

# Members	Intervention Results
102	PCPs have engaged with the lock-in program as a result of an outbound call by an RN to notify them that their patient has been placed on lock-in.
20	Pending PCP confirmation

Future State

With the new carve-in of the pharmacy benefit for Bayou Health members, we agree to:

- Implement a standard lock-in process that will support DHH and that we will operationalize for the new pharmacy program carve-in.
- As part of our clinical programs and services we offer to members, we will offer home visits to high-risk maternity members. We will work with Alere, a home health agency that can go to the member's home to give the injections that prevent pre-term labor and delivery.

Local Pharmacy & Therapeutics (P&T) Committee

In compliance with Section 6.3.5-6.3.5.3, we currently have a P&T committee that represents the needs of all of our members, including members with special health needs. Louisiana network physicians, pharmacists, dentists and specialists, including but not limited to a behavioral health specialist will have the opportunity to participate in the development of the PDL and clinical criteria for medication review. Our P&T committee meets quarterly and reviews medications for inclusion on the PDL based upon clinical efficacy safety, cost-effectiveness and program benefit. Our policy governing the conduct of the P&T committee meetings will include procedures that include an open public forum. We value the public input of local network providers and other health specialists as part of the care team for Bayou Health program members and we will work with other MCOs to develop policies and procedures related to formulary and PDL recommendations.

Administrative Simplification

In compliance with Section 8.10, we will work with other Bayou Health MCOs to develop a common pharmacy administrative framework that collectively meets the requirements of Sections 6.40.1 -6.40.9. As noted above, as an active member of the LAHP, we have already initiated discussions with Mr. Drozda, to develop ways the LAHP can serve as a convener of the MCOs to facilitate this collaboration between MCOs.

e-Prescribing

We will also advocate for other collective methods that support administrative simplification and medication management such as e-prescribing. The importance of e-prescribing brings a new level of preferred versus non-preferred status of a medication for those organizations which have their PDL loaded into Surescripts®. This includes any patient, whether Medicaid or private insurance, as many if not most insurance companies have formularies/PDLs. This program provides physicians and other health care professionals with tools and information they can use to help their patients make better health care decisions. It allows a physician and other health care professionals to verify member eligibility, medication history, and the list of drugs on the plan formulary, and any other prescriber's medications prior to writing the prescription. We recommend that the prescribing community be encouraged to use e-prescribing to resolve the concern prescribers may have on keeping up to date with multiple PDLs and to review

contraindications from other prescribers. We plan to continue to work with the provider community in educating them on the ease of use and transparency that e-prescribing offers them.

Veteran/Hudson Initiative

We are in the process of identifying local pharmacists that meet the requirements of the State's Veteran/Hudson initiative to support the State's efforts. We have identified several pharmacies that are working through the contracting process and expect that, throughout the course of the contract, we will continue to seek out and contract with additional Veteran/Hudson Initiative certified pharmacies.

Q.3 Submit a preliminary plan for MCO oversight of the PBM's performance. (5 points)

PBM Vendor Oversight Program

OptumRx performs administrative, managerial, consultative, claims processing, and other pharmacy benefits management services as have been described herein, but do so under the direction and guidance of chief medical officer Dr. Ann Kay Logarbo. Additionally, regional pharmacy director Shana Bush, Pharm.D, will work closely with Dr. Logarbo and the OptumRx team. For all subcontracted services, including the pharmacy benefit, we maintain complete accountability and oversight for subcontractor performance, and we systematically oversee all subcontractor relationships through our vendor management control processes that ensure subcontractors meet their contractual expectations.

As an integral part of our vendor oversight activities and documentation, we have implemented a PBM Vendor Oversight Program to fulfill this obligation.

Vendor Oversight Program Components

Components of our PBM Vendor Oversight Program include:

- Written policies and procedures
- Monthly monitoring of contractual service level agreement standards, including adherence to DHH Contract requirements
- Monthly monitoring of rebate billing and collections
- Quarterly business reviews and PBM Joint Oversight Committee meetings
- PBM biweekly strategic meetings
- Annual audit, review and report

Written Policies and Procedures

Written policies and procedures define ongoing monitoring and auditing functions we use to ensure services performed by the PBM comply with regulatory and contractual standards. Oversight policies and procedures are created, or updated, as necessary to comply with changes in processes, and to address new federal or state directives.

Monthly Monitoring of Contractual Service Level Agreement Standards

Monthly, the PBM provides a service level standards report, illustrating the PBM's level of compliance with contractual service level standards such as eligibility, call center statistics, claims turnaround time and availability of reports. If an unsatisfactory compliance or service level issue is identified through this ongoing monitoring and assessment, a corrective action plan may be required. Our pharmacy management program evaluates and monitors the effectiveness

of the corrective action plan to ensure that the desired outcome is achieved. Our service level agreement includes this applicable pharmacy section of the DHH Contract.

Monthly Monitoring of Rebate Billing and Collections

Monthly, our business analysts review the rebate reports provided by the PBM. Variances or discrepancies in rebates anticipated and paid, based upon utilization and contractual WAC discount percentages, are communicated to the PBM. A tracking sheet is maintained to keep the discrepant issues open until they are resolved to the satisfaction of pharmacy management.

Quarterly Business Reviews and PBM Joint Oversight Committee Meetings

Members of our pharmacy management and the PBM account team attend quarterly business reviews and PBM Joint Oversight Committee meetings. The scope of the review includes:

- Service level agreement performance, including eligibility, call center statistics, claims turnaround time and reporting
- Fraud, waste, and abuse audit performance and overpayments and recoveries by plan
- Pharmacy cost and utilization trends, including overall per-member-per-month (PMPM) trend, utilization metrics and drug mix metrics for all lines of business

PBM Biweekly Strategic Meetings

Strategic meetings are held with the PBM on a biweekly basis under the supervision of Dr. Bush. A central element of the strategic meetings is an *Issues and Action Items* document known as the IRAAD. This tracking document serves as an outline for discussion, and provides the details and progress of action items requested by Dr. Bush.

Annual Audit, Review and Report

Annually, our vendor oversight associates, in conjunction with the pharmacy management team, conduct an audit, review and report. The report provides detailed findings and recommendations on the following:

- Pharmacy network
- Network claims
- Fraud and abuse/compliance
- Rebates
- Pharmacy help desk
- Service levels
- Business continuity plan

The nature of the audit allows our oversight team to validate the existence of randomly selected network and rebate contracts. The focused time spent on the audit enables the oversight team to meet and communicate with the people accountable for the various functions they perform on a daily basis.

The PBM Vendor Oversight Program ensures that we are in compliance with our contractual obligation to monitor and oversee any of the pharmacy benefit functions and responsibilities. The PBM Vendor Oversight Program attempts to consistently identify, prioritize, and respond to actual or potential non-compliance issues or concerns.

Ongoing Communications with the State

As a current partner with the state of Louisiana, we frequently collaborate with Ms. Wendt to address the needs of our members and to find ways to improve outcomes and lower costs. With the expansion in scope of this contract, including the carve-in of pharmacy and the importance of member transition, we will initiate a weekly pharmacy transition meeting as a forum for issue resolution, stakeholder feedback and any other discussion on the status of the transition. Dr. Bush will lead these meetings and work very closely with the DHH pharmacy team throughout the term of the contract.

Q.4 The drug file for both retail and specialty drugs, including price, must be updated at a minimum every seven (7) calendar days, at the MCO's discretion they may update the file more frequently. Provide a brief summary of your policy, process and frequency for drug file updates. (2 points)

OptumRx uses the Medi-Span Master Drug database file to keep product and pricing information up-to-date. The file includes price updates, product updates and new drug information for all drugs, including specialty drugs. **Our current policy and process applies the Medi-Span files to the claim system twice weekly, exceeding the State's minimum requirement for updates every seven days.** This will be verified as completed by Dr. Bush.

Under the direction of Jim Aoun, vice president, business operations management for OptumRx, reports are generated from the file update process, reviewed and verified. If there are any issues identified in the reports, Mr. Aoun coordinates with his team to validate the information if necessary, documenting the issue on the Medi-Span and Clinical Operations log for tracking and follow up with Medi-Span for research and resolution. Upon resolution from Medi-Span (if required), OptumRx initiates and completes the project to apply the updated information to the system.

Q.5 Submit a summary report of three (3) pharmacy utilization management efforts which demonstrated successful outcomes for three (3) separate disease states. (6 points)

Our approach to pharmacy benefit management is embodied by the principle that pharmacy benefits comprise one component of overall health care and all components are interrelated. In support of that key principle, we developed effective pharmacy utilization management programs and strategies to control pharmacy spending without increasing costs in other health care categories. In fact, sometimes an increase in pharmacy costs is justified by improved health outcomes and decreased overall health care costs (e.g., adherence to asthma controller medication therapy or HIV medication regimens).

The most important aspect of managing pharmacy services is improving our members' overall health status by promoting the appropriate utilization of the most cost-effective mix of drug therapy as illustrated by the three examples below for:

- Hepatitis C - utilization management and clinical management programs
- Asthma intervention
- ADHD drug therapy outreach

Hepatitis C Utilization Management and Clinical Management Programs

The Hepatitis C therapy drug class was a breakout trend driver drug class in 2014 and is anticipated to continue to drive pharmaceutical expenditures in 2015. UnitedHealthcare, through collaboration with experts in the field of hepatitis C treatment, consulting with multiple state

Medicaid programs and internal clinical experts, developed a hepatitis C utilization management program that aims to successfully treat the right patients with the recommended cost efficient regimens specific to their condition.

Our clinical guidelines align with the recommendations of the American Association for the Study of Liver Diseases (AASLD). An important component of the clinical guidelines is to identify the patients that are not only candidates for treatment from a clinical perspective, but also, identify those patients that have a high chance of completing their course of therapy and increasing the chances of a sustained virological response (viewed as being cured).

Adherence to therapy is essential to a successful outcome and is stressed in our authorization criteria and the therapy clinical management programs deployed by our contracted specialty pharmacies. The combination of robust initial utilization management criteria and clinical management program support helps guide these members to successful completion of their therapy. Below is an excerpt from a first order member education brochure that helps the member understand the course of therapy and importance of communication with their care providers.

Hepatitis C Treatment Timeline

Start of Treatment

Start of Treatment
- Learn about hepatitis C, your prescribed medicines and the length of treatment.
- Develop healthy lifestyle habits such as avoiding alcohol, smoking, and illegal drugs for at least 6 months before starting hepatitis C medicines and while you're on your treatment.
- Enroll in a support program such as the OptumRx® Clinical Management Program (CMP).

Week 2

Week 2
- Have a follow-up consult with your OptumRx CMP pharmacist or nurse.
- Talk to your doctor or OptumRx pharmacist about any questions or concerns such as side effects, trouble taking or remembering to take your medicine.

Week 4

Week 4
- Call OptumRx® Specialty Pharmacy at **1-866-218-5445** to refill your medicines if you haven't already.
- If you're having side effects, talk to your doctor or pharmacist. Don't stop or skip your treatment unless directed by your doctor.
- Get necessary blood tests as directed by your doctor.

Week 8

Week 8
- Make sure your medicines are being refilled on time.
- Complete each day of treatment and remain on your medicines, even if you feel better.
- Some people may require treatment beyond eight weeks.
- Review your lab results with your docotor.

Week 12 and Beyond

Week 12
- If you're still receiving treatment, continue with your medicines even if you feel better.
- Maintain healthy habits. Stay active, eat well and get plenty of rest.
- Some people may require treatment beyond 12 weeks.
- Be sure to schedule any additional blood tests.
- Discuss long-term disease management and monitoring with your doctor.

Outcomes

Below is an excerpt from a member tracking database for Hepatitis C patients served by specialty pharmacies in our network. All patients from our Florida Medicaid program achieved the goal of successfully completing the 12 weeks of therapy. The final step is staying in contact with the patient and provider office to assure the end of therapy viral load (EOTVL) blood test is performed. This blood test confirms the sustained viral load reduction and treatment success.

Genotype 1 Patients												
Gender	**Age**	**Genotype**	**Treatment Status**	**Fibrotic Score**	**Coinfected**	**Drug Name**	**Therapy Stare Date**	**Initial Viral Load**	**Therapy End Date**	**Weeks on Therapy**	**12 week EOTVL Value**	**Patient Status**
F	64	1A	Naïve	4	No	S/P/R	1/31/2014	375,170 I.U.	4/24/2014	12	1,000 I.U.	Completed Therapy
M	60	1A	Replapser	3	No	S/P/R	4/6/2014	815,130 I.U.	6/28/2014	12	EOT 12 9/15/2014	Completed Therapy
F	56	1A	Naïve	4	No	S/O	5/15/2014	2,200,000 I.U.	8/6/2014	12	EOT 12 11/6/2014	Completed Therapy
M	55	1A	Naïve	N/A	No	S/O	6/9/2014	2,913,011 I.U.	8/31/2014	12	EOT 12 11/24/2014	Completed Therapy

Asthma Intervention

Consistent use of baseline controller medications is important to the successful treatment and control of asthma symptoms. Non-adherence to the asthma maintenance medications (e.g., Flovent, Singulair, Dulera) is a common reason for less than optimal management of asthma; which can lead to missed days of school, ER utilization and hospitalization. The goal of this intervention is to identify the target population that may benefit from education on the importance of asthma medication adherence.

Members in our Florida Medicaid program with two or more claims for a short acting beta2-agonist inhaler (without a corresponding claim for a respiratory maintenance medication within the identification period) were provided an asthma educational packet via U.S. Mail. The purpose of the brochure was to increase health literacy regarding the importance of proper asthma medication use and the positive outcomes of taking medications as prescribed by their doctor.

Outcomes

Utilization of both short- and long-acting respiratory medications and hospital days were compared 120 days before and after the intervention date with the following outcomes:

- 28.3 percent increase in long-acting respiratory med utilization
- 18.1 percent decrease in short-acting inhaler claims
- 18.6 percent reduction in number of members using the hospital post-intervention
- 37.7 percent reduction in number of hospital days post-intervention

Attention Deficit Hyperactivity Disorder Drug Therapy Outreach

The group of medications used to treat attention deficit hyperactivity disorder (ADHD) is often a top therapy class by both drug expenditure and utilization in the Medicaid population. We employ multiple utilization management strategies for these drugs to ensure clinical appropriate cost effective care:

- ***Age Edits:*** Use below minimum age edits requires prior authorization
- ***Quantity Limits:*** Maximum dose edits and dose consolidation- excess quantities require prior authorization
- ***Prior Authorization:*** Validates appropriate use, based upon Food and Drug Administration guidance or literature supported diagnosis; also prevents diversion

Drug therapy is an important part of ADHD treatment. However, ongoing patient contact with the provider is essential successful outcomes. This is particular true for members new to therapy, as evidenced by the HEDIS quality metric for ADHD follow-up care.

Attention Deficit Hyperactivity Disorder Intervention

To promote treatment success, we make outbound calls to prescribers and members in our plan who recently began ADHD therapy. The goal is to make sure they have a follow-up appointment within 30 days of their first script being filled.

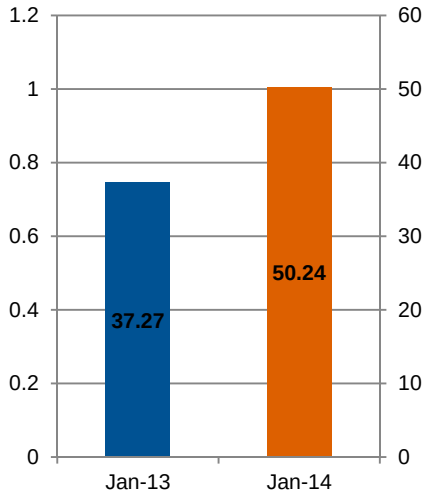


Figure 39. ADD-i HEDIS Intervention Success for Follow-Up Care (2013 vs. 2014).

We verify if the follow-up appointment has been scheduled, and if not encourage the office to contact the member to schedule the visit. This ADD-i (Follow-Up Care for Children Prescribed ADHD) HEDIS medication measure follows national guidelines for the appropriate monitoring and follow up for our members when prescribed ADHD medications.

Outcomes

The result of this intervention in our Florida and Mississippi Medicaid programs yielded the following member outcomes:

- ***July 2013:*** Children in our program within the age limits for ADHD, showed an interim HEDIS rate for follow-up care in the 75th percentile (37.27)
- ***July 2014:*** One year later, as a result of the educational intervention, the interim rate is in the 90th percentile (50.24)

Q.6 Describe at least 2 and no more than 4 existing or proposed educational initiatives the PBM or MCO will take regarding the use of Behavioral Health Medications (including ADD/ADHD), treatment of infectious diseases, and the treatment and control of diabetes or asthma

Retrospective Drug Utilization Review Program

Our Retrospective Drug Utilization Review (rDUR) program focuses on minimizing the health risks and cost impact caused by the inappropriate use of pharmaceuticals. We conduct analysis of pharmacy claims data to identify members who have processed a pharmacy claim during a defined time period for a drug (or combination of drugs) that could potentially put the member at risk of an adverse event. We reach out to providers who have prescribed the medications for the identified member and alert them of the potential risk. The rDUR program is a comprehensive program that screens for five scenarios identified as potentially increasing the risk of an adverse event, these scenarios include:

- ***Drug-Drug Interaction Alert Program (DDIAP):*** A provider-targeted program designed to minimize the occurrence of significant, patient-specific drug-drug interactions as recognized by: American Health Formulary Services (AHFS), CMS Patient Safety Analysis Report: Drug-Drug Interaction Measures, drug-specific prescribing information, Facts and Comparison, Hansten and Horn's Drug Interaction Analysis, Micromedex.
- ***Dose Duration Rx Monitor Program:*** This is a provider-targeted intervention designed to enhance provider awareness on appropriate medication dose and duration use based upon approved prescribing information.
- ***Drug-Age Rx Monitor Program:*** To detect and minimize the occurrence of potentially inappropriate medications (PIMs) in the elderly (65 years and older) and pediatric (less than 18 years) population. Geriatric targeted PIMs are determined by the HEDIS 2014 measure "Use of high-risk medications in the elderly (DAE)." Within the pediatric (less than 18 years) population, a primary focus is the use of atypical antipsychotics for members under the minimum FDA approved ages.
- ***Polypharmacy – Duplicate Therapy Program:*** This is a provider-targeted intervention designed to promote awareness on duplicate therapy polypharmacy concerns.
- ***Narcotic Drug Utilization Review Program:*** This program is a provider-targeted intervention designed to minimize the occurrence of drug abuse, diversion, and inappropriate use in members using high-risk medications.

All the above programs send provider intervention letters. The providers also receive a member-specific provider report that includes the clinical issue of concern, the clinical rationale supporting the issue, and a prescription utilization report detailing the interacting medications. The DDIAP program sends daily provider intervention letters; the remaining program send monthly intervention letters. The following table illustrates the program results.

Program	Patients	Prescribers Contacted	Patient Alerts	Alerts Analyzed	Success	Success (%)	Estimated Cost Savings
Dose-Duration Rx Monitor	14	12	14	13	4	30.77%	$13.98
Drug-Age Rx Monitor	34	27	34	32	13	40.63%	$5,758.03
Drug-Drug Interaction Alert	451	392	499	265	164	61.89%	$14,544.24
Narcotic Drug Utilization Review	659	962	788	753	425	56.44%	$14,486.38
Polypharmacy Duplicate Therapy	134	113	135	132	77	58.33%	$10,948.69
Grand Total	**1292**	**1506**	**1470**	**1195**	**683**	**57.15%**	**$45,751.32**
PMPM YTD	**$12.07**						

Suboxone Dose/Duration of Therapy Intervention

Suboxone (Buprenorphine) is a medication that is approved for treatment of opioid addiction. When used as directed, this drug is not a heroin/opioid substitute. It is prescribed or administered under monitored, controlled conditions and is safe and effective for treating opioid addiction. It is administered sublingually in specified doses.

To assure guideline-based appropriate utilization and to protect against diversion, we were a market leader to develop robust prior authorization criteria. We partnered with Optum Behavioral Health experts about the use of Suboxone/Subutex therapy for office-based treatment of opioid dependence. **One of the outcomes of this partnership was the development of Suboxone prior authorization criteria.** If therapy is approved there are two phases:

- Up to 24 mg/day is approved for the first 90 days (induction phase)
- The authorized dosage is reduced to a maximum of 16mg per day

We expect to see a reduction in dosage after the induction phase. Clinical literature indicates that the recommended dosage for stable patients is 16 mg/day or less. However, not all patients can be stabilized on this dose initially, and over time the dose may be able to be reduced.

Educational Intervention

The educational intervention was to outreach via letter with a follow-up physician peer-to-peer phone call to outlier prescribers of Suboxone that have patients on a Suboxone dose of greater than 16mg during the maintenance phase of therapy.

We identified those members with opiate dependencies that were being prescribed Suboxone at doses greater than the state best practice clinical guidelines. After the initial induction phase, we

recommend that members be treated with the maximum of 16 mg/day in the stabilization (maintenance) phase.

An analysis of our membership during the project time frame revealed that:

Criteria	Results
Users of Suboxone for 90 days or longer equal	4,533 members
Percent of members on greater than 16 mg/day after 90 days of initial therapy	7.2 percent
Members that are receiving Suboxone maintenance doses above the recommended 16 mg/day	330 members (or 7.2 percent of Suboxone prescriptions)
Outlier members	Clustered in certain states with only one true outlier state.

The intervention consisted of a letter to the prescriber outlining treatment guidelines for the use of Suboxone and also a list of patients receiving a dose greater than 16mg after the initial 90 days of therapy. The letter requested that the physician evaluate these patients for a possible dose reduction. The letter was followed up by a call from a medical director to the prescriber to discuss the purpose of the letter and the opportunity to evaluate the patients for dose adjustment.

Although benchmarks are not available for the percentage of members that require a maintenance dose of greater than 16mg, our clinical experts believe we can reduce the number of members on a maintenance dose greater than16 mg/day. The premise is that these outliers are due to a provider knowledge gap and lack of continued attempts to reduce the dose. Our goal is to reduce number of members on maintenance doses of Suboxone by 50 percent--from 330 to less than 165.

This is an ongoing project and results are pending. The initial feedback from the outbound peer-to-peer calls is positive. Intervention is occurring and in the next three to six months we will evaluate pharmacy claims data to determine the impact of the intervention and will share these results with DHH.

Refill Reminder and Pharmacy Adherence Member and Provider Education Program

Adherence is defined as taking a medication as prescribed by a health care professional. Non-adherence can lead to morbidity and mortality. As compared to non-adherent members, adherent members have lower likelihood of hospitalization, ER visits and condition-specific health care costs. Despite high health care costs and the morbidity and mortality risk associated with non-adherence, only approximately 50 percent of members are adherent to their chronic medications. The Refill Reminder and Adherence Program provides refill reminder interventions for non-adherent members and engages their providers with the goal of increasing adherence to chronic medications and decreasing health care costs. These goals, along with the medication classes targeted by the program, are consistent with standards outlined by the HEDIS, Pharmacy Quality Alliance (PQA).

Background Facts

- Approximately 20 percent to 30 percent of medication prescriptions are not filled
- On average, 50 percent of medications for chronic diseases are not taken as prescribed

- More than 33 percent of medication-related hospital admissions are linked to poor adherence
- Medication non-adherence results in $100-$289 billion annually in direct costs to the U.S. health care system

Methodology

- We use pharmacy claims and medical claims data to identify members who are non-adherent to any medications within the following medication classes:
  - **Antidepressants**
  - **Antipsychotics**
  - **Antiretroviral HIV/AIDS medications**
  - Beta-blockers
  - Calcium channel blockers
  - **Diabetes medications**
  - Osteoporosis therapy
  - Renin angiotensin system antagonists [angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs) and direct renin inhibitors]
  - **Respiratory long-term control medications**
  - Statins

Targeted members are reminded to refill their medications via HIPAA-compliant, outbound calls from an automated message delivery system. Targeted members' providers can also receive a mailing that includes a letter introducing the program and a provider-specific report detailing members who may be non-adherent to medications within the targeted medication classes.

Program Components

- Member-targeted intervention
  - Automated HIPAA-compliant refill reminder call(s) with up to three non-adherent medications listed in each call
- Provider-targeted intervention
  - Provider letter explaining the program and its goal
  - Provider report that includes 120-day pharmacy claim history and proportion of days covered value for each non-adherent medication class (member and non-adherent medication class specific)

Program Benefits/Outcome targets

- Increase members' adherence to chronic medications
- Decrease overall health care costs
- Improve HEDIS performance measure

Section R: Customer Service

R.1 Provide a narrative with details regarding your member services line including:

- Training of customer service staff (both initial and ongoing);
- Process for routing calls to appropriate persons, including escalation; The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity);
- Process for handling calls from members with limited English proficiency and persons who are hearing impaired;
- Monitoring process for ensuring the quality and accuracy of information provided to members;
- Monitoring process for ensuring adherence to performance standards;
- How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g., Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and
- After hours procedures. (10 points)

We currently provide a member services line for our Louisiana Medicaid and CHIP members, serving the needs of over 275,000 Bayou Health members. We consistently meet or exceed the requirements and performance standards and agree to comply with the specifications and requirements outlined in Sections 12.15, 12.16 and 12.18. One of our greatest resources is our well-trained member services staff, already experienced with assisting Louisiana members. They are committed to connecting with this population and providing them with continued quality service.

> "She was able to pull up her information with no problem and explain the situation to me and let me know what I needed to do from there. And I appreciate it very much and I appreciate you guys."
>
> *Louisiana member who called our member services line after misplacing her daughter's ID card*

Our member call center, located in Houston, will continue to support Bayou Health members and providers with the same high standards and performance that has been delivered under our CCN-S contract. This strategy ensures that members and providers will continue to have access to our experienced and dedicated staff (many of whom are from Louisiana, relocated after Katrina) and that in the event of natural disasters in Louisiana, will support our members without interruption.

In this section, we provide a description of our customer service approach, followed by new Bayou Health member onboarding and ongoing member support.

Our Bayou Health Member Services Helpline

Our member services center serves as the single point of contact for all member inquiries and a call to this line can sometimes be the first encounter our Bayou Health members have with us. This connection is vital to our ability to show these members how much we value them and we work diligently to provide an enjoyable and satisfying experience. We are currently providing Bayou Health members with a prompt connection through a single telephone number to a well-trained staff. Our staff provides fast, reliable and accurate service with compassion and an understanding that our members are individuals with unique needs.

We provide a straightforward one-stop experience for our Bayou Health members and our member service representatives (MSRs) respond to inquiries and concerns with the goal of

addressing the member's reason for calling during the initial call. In addition to our experienced Bayou Health staff, our member services center uses state-of-the-art technology, which allows our MSRs to rapidly access information and provide a fast and accurate response. MSRs assist members with benefits and eligibility; completing their health risk assessment (HRA); finding, choosing and scheduling an appointment with a high-quality provider. In addition, each MSR is notified if members have gaps in care (e.g., well-child checkups, immunizations) and will work to make sure they are scheduled with the appropriate PCP or specialist for resolution. MSRs connect high-risk members with case managers to provide ongoing support for any complex clinical needs. MSRs can also assist Bayou Health members with community resources, arranging transportation to an appointment and more. If unable to answer a question, the MSR connects the member to someone who is able to help by conducting a warm transfer or three-way conference call.

We will continue to provide Bayou Health members with access to NurseLine, which is available 24 hours a day, seven days a week. NurseLine is staffed with registered nurses to address member questions and triage immediate health concerns. NurseLine services include telephone crisis intervention, risk assessment and consultation to callers that may include family members and other community agencies seeking assistance with behavioral health issues.

Bayou Health Member Onboarding

Our current onboarding process for Louisiana members has been extremely successful, providing timely, helpful and relevant information that has resulted in higher member satisfaction.

In 2014, our successful onboarding of Louisiana members included the following:

- 28,000 new members were welcomed in January through July
- We completed initial health risk assessments through outbound calls for 45.2% of these new members

After enrollment, our onboarding process begins with an initial welcome call, reaching out to the member within 14 business days of sending our welcome packet (in compliance with Section 12.11.3.2.1) to provide the following services:

- A personalized welcome
- A summary of the plan and benefits overview
- Information verification, such as address and receipt of materials
- Verification that the member has a PCP that meets his or her needs, or assistance with appointment scheduling if the member has not seen a physician within the last 12 months
- Discussion of preventive or other topics, as needed
- Completion of a comprehensive HRA to appropriately stratify the member according to his or her clinical, behavioral or social needs
- Connections with any necessary community or clinical services

Bayou Health Ongoing Member Support

After the initial welcome call, MSRs take traditional "customer service" to the next level by responding in a holistic manner to any questions the member has, anticipating related questions and future needs. In each interaction with the member, MSRs verify that every member of the family has a PCP, and has seen their PCP to receive all preventive care, including EPSDT screenings, immunizations, etc. MSRs also leverage the members' clinical profile to coach them with appropriate ways to manage their conditions and implement lifestyle health improvements.

Initial and Ongoing Customer Service Staff Training

We have existing Bayou Health training programs and experienced trainers already in place within our member services center, focusing on Louisiana member engagement and satisfaction.

Our hiring strategies for Bayou Health MSRs include an effort to find employees who understand and appreciate the unique needs of each individual member, with a passion for service and care. One strategy we use in recruiting MSR trainees is to employ individuals who were previous recipients of public assistance themselves, as they bring the ability to establish a particular rapport with our members. MSRs are trained to handle a broad range of complex topics, with appreciation for privacy issues and sensitivity to members with disabilities and different cultural backgrounds.

In addition to in-depth telephone etiquette and systems training, our MSRs receive training on Bayou Health benefits, Louisiana health and social service resources, provider networks, handling calls in an emergency and cultural competency. The various types of training that are provided (e.g., general compliance training, new MSR training, Louisiana-specific training and ongoing training) are detailed in the sections below.

General Compliance Training

New employees are required to complete general compliance training within our new employee orientation. This training includes, but is not limited to:

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

For new MSRs, compliance training is required and is a condition of employment. This essential training includes education on our *Code of Conduct*, *Principles of Integrity and Compliance*, and provides information about our Compliance HelpLine, a toll-free phone line (available 24 hours a day, seven days a week) designated for reporting incidents of suspected non-compliance or other misconduct. Supervisors are responsible for ensuring that each direct-report employee completes the applicable compliance training, acknowledges receipt of our *Principles of Integrity and Compliance* brochure and agrees to review the brochure within 30 days. Employees must complete our online *Integrity and Compliance@Work* training programs upon hire and at least annually thereafter. Completion of the training programs is documented and records are maintained by our human capital team. MSRs have access to online tools, policies and procedures. These resources are written as step-by-step processes to be easily understood and to provide consistent information.

Initial Member Services Representative Training

New MSRs receive two phases of customer care training during the beginning of their employment. MSR training will progressively move the individual from learning the basics of the DHH program and Bayou Health operations, to simulated interactions with members and testing, to ultimately interacting directly with members under direct supervision. Each topic is addressed through a variety of training vehicles, including reading, lecture, role-playing/simulations, observation and question-and-answer opportunities, with intermittent

reviews to confirm information is retained. MSRs must pass written evaluations and meet specific metrics before they move to the second training phase and are allowed to take calls on the phone. Once on the phone, supervisors monitor MSR calls to help them achieve a pre-determined quality level of service and to identify areas of retraining. Specialized training is warranted for MSRs who are not meeting the metrics.

The two-phases of initial MSR training are outlined in the following table:

Customer Care Training Topics	
Phase I Training Topics	**Phase II Training Topics**
▪ Our customer care philosophy and approach ▪ Introduction to the Louisiana Bayou Health program ▪ The role of the MSR as the member's first point of contact with the plan ▪ Integrity and compliance ▪ Program structure, including medical management functions, claims functions, member services and provider services ▪ Basic member services skills, including active listening, questioning, responses to look for and "flags" indicating the member may not understand materials ▪ Cultural sensitivity including training around the geography of Louisiana, the culture and the correct pronunciation of cities, towns and family names, in compliance with Section 4.6.3. ▪ Systems introduction (IT, telephone and contact tracking system) ▪ Health program and benefit explanation, including categories of eligibility ▪ Introduction to member materials, including content, intent and distribution ▪ UnitedHealthcare and DHH's websites (accessing information and instructing members on their use)	▪ Phase I review ▪ Introduction to other entities participating in the programs ▪ Member services process, policy and procedure ▪ Questions frequently asked by members ▪ Recognizing issues that need to be escalated or transferred to another department ▪ Appropriate documentation of calls via tracking systems, including complaints ▪ Using available tools, including online manuals, workflow diagrams, reference materials, mapping search engines and job aids ▪ Using the interpretation services reference guide for involving interpreters when working with members with limited English proficiency ▪ Ongoing performance improvement efforts ▪ Claims system introduction

Our MSRs receive training during new employee orientation, annually and on an ad hoc basis on handling urgent needs or situations. MSRs are trained to recognize symptoms of a medical crisis such as slurred speech, altered consciousness and shallow breathing. We review and discuss urgent situation calls during training example scenarios and role play how to respond so our staff feels competent to answer calls of this nature.

Louisiana-Specific Training

We recognize that each state has a unique culture, and in addition to comprehensive member services training, our MSRs attend our State School. State School curriculum is developed specifically for each state and gives our MSRs the opportunity to truly understand and relate to the specific member populations they serve. Our MSRs are very proud of the states they represent, and spend time learning about all the distinctive aspects of the state.

Louisiana-specific training begins with an overview of the rich history of the state, as outlined through interviews with state museum curators and university professors. It is important to share records of the past with our MSRs to promote an understanding of present-day Louisiana. MSRs also learn about the various industries in the state, including the tourism industry and the huge historic and cultural draw of New Orleans, along with the festivals and celebrations.

A fundamental area of education involves the geography of Louisiana, from the bayous and swamps, to the Mississippi River, to the corn and rice fields, to the large cities and other points in between. It is vitally important that our MSRs learn about Louisiana geography so they are equipped to assist our members with their needs, while understanding the geographical makeup and constraints of various cities and towns. MSR training on Louisiana geography includes, but is not limited to:

- Southeast Louisiana and New Orleans
- The Northshore and Lake Pontchartrain
- The Acadiana area and Lafayette
- The capital area of Baton Rouge
- Northern Louisiana and Shreveport
- Central Louisiana and Alexandria

Subsequent training includes instruction on other principal aspects of Louisiana, such as the distinctive cultures and people of these areas, member demographics and the numerous influences of Spanish, African and French ancestry. Training is also provided to assist MSRs with the pronunciation of cities, towns, parishes, streets and family surnames and how to understand the various dialects and phrasing that makes our Louisiana members unique.

Ongoing Training

Ongoing training is a key component to maintaining an effective member services center and we regularly review the MSR resource materials and tools. Our comprehensive ongoing training program includes several components:

- Training materials that are reviewed annually (or as applicable) by the training and development team
- Supervisor monitoring of calls followed by one-on-one coaching
- Annual MSR refresher course
- Ad hoc training sessions led by supervisors and conducted through web-based tools, one-on-one coaching sessions or team meetings as trends and issues or benefit changes are identified
- General refresher course on important topics such as member experience, ethics and confidentiality
- Weekly newsletters to all MSRs that include reminders regarding policy and procedures and activities (e.g., mailing, benefit changes)

Ongoing staff training addresses the cultural and linguistic characteristics and special health care needs of our member population, including: use of our member's first language; cultural awareness and understanding of health disparities among different cultural groups; cultural beliefs related to health, illness, medical care and end-of-life issues; the need to treat each person

with dignity and respect; how to avoid stereotypes; communication protocols for members with limited English proficiency; characteristics of and barriers facing individuals with special health care needs; cultural competency and adult sensitivity training.

We also provide ongoing training through Behavioral Analytics, a member services behavioral program that assists our MSRs in matching their communication style to the personality of the caller. Using linguistic patterns, not voice tone, we are able to identify when a caller is in distress, or when something has become important to them. MSRs are trained to identify those verbal cues and the best way to respond. We record the calls that come into our member services center, and all recorded calls are available to review and analyze though our behavioral analytics capabilities. As a result, Behavioral Analytics has improved the overall member services experience through the elimination of repeat calls and an increase in first-call resolution.

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

Process for Routing Calls to Appropriate Persons

We use a combination of analysis and technology to appropriately route calls and to manage call volume so that our call metrics remain stable and we meet performance requirements. Our National Operations Center supports all of our call centers with operational monitoring of call center results and trends to assure adequate capacity for routing calls to appropriate, trained persons.

Call center technologies used for our Louisiana member call center manage the flow of all incoming calls to provide timely responses to member inquiries. Automatic call distribution and interactive voice response (IVR) skill-based and priority call routing successfully link Bayou Health members with MSRs who are trained on the Bayou Health program and ready to assist. Under the new contract, we will also apply “natural language” technology, where Bayou Health members will be asked to verbally state the reason for their call. This innovative “natural language” capability recognizes more than 70,000 keywords and can categorize the call based on the member’s statement. Collectively, information accessed from these technologies will be 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 Bayou Health members’ questions using relevant information, including any recent visits to the doctor or ER, interactions with our care management team, and any recent family member calls.

As needed, MSRs make warm transfers to our NurseLine, member-assigned case managers, LogistiCare (non-emergency medical transportation [NEMT]), or applicable community services.

In addition to accessing live member services staff during the hours of 7:00 a.m. to 7:00 p.m. Monday through Friday (with the exception of state holidays), Bayou Health members have access 24 hours a day, seven days a week to our IVR system, which provides options such as:

- Instructions on what to do in case of emergency
- Direct transfer to NurseLine to speak with an RN
- Leaving a message, including instructions on how to leave a message and when the message will be returned

A high level IVR system flowchart is illustrated below:

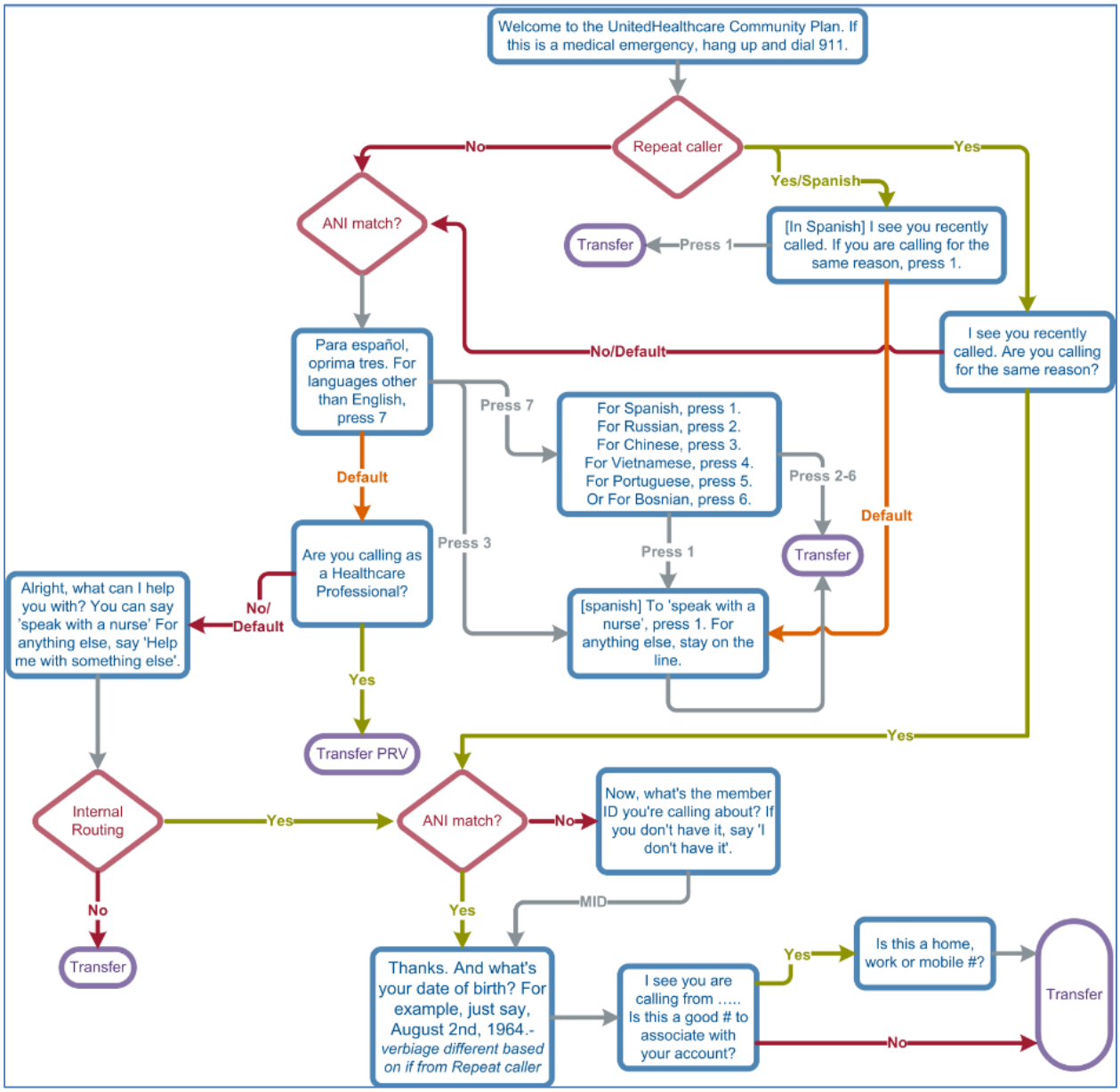


Figure 40. IVR Decision Tree. A high-level chart demonstrating the call decision tree.

Call Escalation

MSRs are trained to recognize issues that need to be escalated or transferred to another department. If unable to resolve a member's issue, the MSR escalates the call, through a warm transfer or three-way conference call, to our customer response group for additional support. The customer response group is a specialized team within the member services center that provides hands-on support for our MSRs. Additionally, for escalated member issues, we engage the health plan operations, particularly for those issues related to appeals and grievances. All escalated calls are tracked to confirm they are resolved within the time frames requested.

Our clinical model enables us to connect member services and clinical teams through care coordinator associates. Care coordinator associates are available to accept warm transfers from our member services teams, serving as a bridge between our people, systems, providers and processes to make sure the member's needs are met in a timely manner. As members of the clinical team, care coordinator associates resolve care coordination issues, including receiving requests for services, working with our care coordinators to assist getting services in place and following up with members and providers to confirm services and other support are received.

Managing Escalation into Behavioral or Crisis Lines

Member transfers are dependent on the nature of the member need (e.g., life threatening, such as needs a backup ventilator, suicidal remarks, or complaints of chest pain versus out of necessary medications or supplies). MSRs are trained to react swiftly and calmly in the presence of a caller who is experiencing an emergency or crisis situation. These events can produce emotional, physical or behavioral distress leading to a crisis and can involve:

- Medical illness
- Mental illness
- Life threatening situations
- Criminal victimization
- Drastic changes in relationships
- Natural disaster (e.g., tornado, flood)

A crisis phone call is one where the caller:

- Perceives to be in crisis
- Is threatening to do harm to others
- Is threatening to do harm to self

For any of these emergencies, MSRs are trained to provide support and obtain immediate assistance for the member. Specific protocols are in place to handle these situations and include calling 911 and transferring calls to the Behavioral Health Crisis line.

NurseLine is available for Bayou Health members 24 hours a day, seven days a week, where calls are answered by an RN who can triage immediate health concerns and conduct telephone crisis intervention.

Information Available to Member Services Staff

We understand the importance of providing our MSRs with the most current information available to assist our call-in members in the most thorough, effective way possible. Our MSRs have both clinical and non-clinical information available to efficiently and accurately answer Bayou Health members' questions. In fact, our member services model goes further in that MSRs are expected to anticipate member needs and future issues using their skills, experience and broad range of up-to-date member health data as described in the table below:

Information/Tools	Source/Description	Update Frequency
Clinical Information	▪ ***CareOne:*** The framework within which we share clinical information serving as a virtual medical record. Provides member risk stratification and scoring to target specific populations and individuals for different levels of care management. CareOne provides HRA tools and hospital admission information. ▪ ***Consumer Dashboard*** consolidates member specific data across all consumer touch points (e.g., behavioral health, pharmacy, EPSDT) into a single member "snapshot," providing a common member view across UnitedHealthcare resources.	Real-time
Member Benefits	***Benefit Summary:*** Used to assist callers with benefit information, including whether services are covered or require authorizations. The benefit summary provides information related to the member's Bayou Health program. These documents are loaded into the MSR's online application and provide a direct link to the benefits and services tied to each member. This information includes information on carved out services such as behavioral health and dental benefits. The NEMT (transportation) information is also included here, although members can be automatically connected to LogistiCare, our transportation provider, if they need NEMT services.	Timely updates as they become available
Provider Network	***Network provider data*** including panel and provider contact info.	Daily refresh
Member Assistance	***Interpretation Services:*** In addition to our Spanish-speaking and other bilingual MSRs, our interpretation services are available at no charge in more than 170 languages to help MSRs assist our members who speak a language other than English.	Timely updates as available
Eligibility & Claims	▪ ***Member Online Services:*** An online tool that MSRs use to access member eligibility, PCP and benefit information. ▪ ***CSP Facets:*** Our main transaction system that MSRs access to obtain member and provider information, including additional information on member eligibility and claims transactions.	Daily and monthly upload (834 files)
State-Specific	***One Source:*** Used to train staff on Louisiana-specific summary level information, including benefits included within the plan, contracted providers and accessibility. Basic information, benefits, demographic and geographic information regarding Louisiana is also included to provide MSRs with an understanding of the Louisiana programs.	Timely updates as they become available
Issue Resolution	***MACESS (online routing system):*** Our internal communication system used to route issues for resolution between departments.	Real-time
Call Quality and Training	▪ ***MyCoach:*** An online tool to aid in the handling of member calls. It provides both global and Louisiana-specific program information for our MSRs including job aids and bulletins. ▪ ***LearnSource:*** Our companywide, web-based training application focused on professional development, cultural competency, company policies, state and federal regulations and compliance. Allows MSRs to take training courses on their own time. Supervisors track completion using automated tools and reports.	Timely updates as they become available

Services are provided to our Bayou Health members using a well-trained staff equipped with tools to assist them in addressing inquiries, questions and concerns. Our goal is to address all requests during the initial call, and our MSRs are best able to do their jobs when they have the proper training and tools.

Process for Handling Calls from Members with Communication Challenges

To provide the best service for our Bayou Health members with communication challenges such as limited English proficiency and hearing impairment, we determine the need for changes or additions to verbal and written member tools. We determine this need by collecting data on ethnicity and preferred written and spoken languages for members and we conduct analyses of this data to perform a cultural and linguistic assessment. We track the number of incoming calls to the member services center requesting the use of an interpreter via our interpretation services, and the number of requests for materials written in languages other than English or in alternative formats, to ultimately best meet our Bayou Health members' health care needs.

Assisting Members with Limited English Proficiency

Delivering a consistent member experience as part of our "one-stop" service model includes focusing on the quality of the interaction with our members and providing personalized service, including speaking to the member in their first language. Accessible and appropriate linguistic services are the foundation of culturally proficient health care; and upon enrollment into our health plan, the member's need for linguistic and translation services is determined and noted in the member's record. We currently employ MSRs who are fluent in Spanish to assist our Spanish speaking members in Louisiana, and our interpretation services are always available to provide our members with access to more than 170 languages to meet their communication needs. The main languages recently requested by our Bayou Health members from our language line (April through June 2014) were Spanish at 96 percent, followed by Vietnamese, Arabic and Portuguese, each at 1 percent.

Assisting Persons Who Are Hearing Impaired

We use the 711 National Telecommunications Relay Service (TRS) TTY line to facilitate communication with hearing impaired members, and print the telephone contact information on all member mailings and marketing materials. MSRs are trained on handling calls from TRS operators who are assisting our hearing impaired members. When the office is closed, the TRS operator can leave a message on the system requesting a call back. Those messages are returned by the next business day using TRS via 711.

Monitoring for Quality and Accuracy

On a regular basis, supervisors perform call monitoring activities to make sure performance standards are being met by MSRs. All call data is captured and measured via a call distribution system. Supervisors also conduct silent monitoring of live calls to make sure MSRs are providing members with accurate information and adhering to established policies and procedures on timeliness, professionalism and cultural sensitivity. All inbound and outbound member services calls are recorded so that random samples can be monitored. Taped calls are listened to at least one day per week, allowing quality reviews and feedback to be recorded and later provided to the MSRs. This monitoring of Bayou Health member call experiences provides supervisors with the opportunity for the continuous clarification of information.

The quality review process includes the following:

- ***Randomly audited calls per month (per MSR):*** These calls are pulled from the recordings within our call distribution system. We audit a minimum of 10 calls per month for the first 90 days for new MSRs. After the first 90 days, we monitor four calls per month per MSR. For each call audited, the MSR is scored by our quality coach on each of the six key call components:
  - Phone technique
  - Building trust
  - Accurate response
  - First call resolution
  - Education/activation
  - Policy adherence
- ***Documentation process:*** MSR scores are documented on a Quality Service Form
- ***Audit-the-Auditor process:*** Every Quality Service Form is audited daily to confirm consistent and accurate scoring
- ***Live monitoring:*** Supervisors monitor live calls and provide immediate feedback
- ***Special requests:*** Ad hoc audits are conducted as requested by a supervisor or manager
- ***Call Calibration:*** Call center management meets twice monthly with our leadership teams who support Bayou Health performance management, operations, compliance and member outreach to listen to recorded phone calls and provide input regarding how the call was handled.

Our Continuous Improvement Training and Development program includes the following:

- Quality audit results are tracked for all MSRs to identify trends in areas of improvement
- The training director reviews trended results and adjusts the training curriculum as necessary
- MSRs receive daily feedback of performance relative to targets within performance management system, focused on:
  - Quality scores
  - Post-call survey scores
  - Key performance metrics

We also apply our Behavioral Analytics program to provide feedback for the MSR on effective communications.

Member Satisfaction

Member satisfaction scores are important because they show how successful we are at onboarding our members, communicating with providers, helping members when they reach the member services center, creating materials that are easy to use, and developing programs that are valued by our members.

Consumer Assessment of Healthcare Providers and Systems Survey

The CAHPS survey is the primary method that our State customers use to rate satisfaction compared with other health plans. Most importantly, improvement in the CAHPS scores is validation that we are succeeding in our mission to help people live healthier lives. There are several questions on the survey that specifically address the member services experience. These results are used as key indicators of our members' experience with their individual providers and with UnitedHealthcare. In our 2013 CAHPS survey, 86.09 percent of Louisiana members surveyed rated the health plan at least an eight on a scale from 0 to 10 (75th percentile). This was the highest rating among all Bayou Health plans.

We use information and member feedback to continuously improve our members' call experience. For example, through a national workgroup, we worked with our member services center to create a dedicated campaign around *Build Community* to make sure our MSRs understood the importance of providing helpful service and treating all of our members with courtesy and respect to enhance the member's experience.

Post-Call Survey

A post-call survey is also used to assess our members' experience and evaluate the performance of Bayou Health member services staff. Following each call, members are given the option to participate in a phone survey. Participating members are asked six questions that are rated on a 1 to 5 scale (5 being the best). The results of the survey are monitored on an ongoing basis by member services quality staff. The quality team calibrates data collected through the survey and looks for trends and opportunities for improvement at the individual and group level and intervenes and provides training as needed. We are able to use text search on our digitally recorded calls, which is an additional way to identify trends in concerns or issues.

Bayou Health United Experience Survey (UES) Results
Our 2014 year-to-date Bayou Health member satisfaction survey results are **95.86 percent**, exceeding our internal member satisfaction target of 94 percent.

Members who indicate a dissatisfactory experience through the survey process receive a follow-up call from staff. Survey questions include:

- How satisfied are you with the services you received from our MSR?
- Was the MSR polite to you?
- Did the MSR understand your issue?
- How hard did you think the MSR worked to help you?
- Did your MSR resolve your issue using language that was clear?
- Do you trust the MSR's expertise and knowledge regarding your particular issue?

We are committed to resolving member issues. If a member indicates they are dissatisfied with their experience, the call is flagged for follow up and resolution by a supervisor. Member services captures calls using the subject and category codes selected within our CSP application. Reports are generated monthly, including any complaint calls received within the member services center. Information from this report is shared with DHH, providing insight as to why members are calling into the member services center. In addition, any complaint call records that are sent to our appeals unit are captured, and this information is provided to Larry Smith, program integrity officer.

Monitoring Processes to Ensure Adherence to Performance Standards

We currently **exceed the performance standards** for the Bayou Health population and will comply with the call center performance standards requirements in Section 12.16.14.

Current performance metrics for February 2012 through July 2014 for the Bayou Health program are demonstrated in the following table:

Compliance Scorecard	Targets	2/1/12 to 7/31/14
Member % ABR	5%	<1%
Member ASA (seconds)	30	10.08
Member % SVL in 30 seconds	95%	100%
Average Hold Time (seconds)	180	6

Monitoring call metrics

Within our member services center, we use standard call center metrics including:

- Member engagement specialists welcome calls made within 10 days of enrollment
- Total calls answered
- Total calls handled
- Average speed of answer
- Percent of calls answered within 30 seconds
- Average hold time
- Abandonment rate

Tracking Processes

Because we recognize the importance of measuring and monitoring our member services metrics, our tracking process includes the following approaches:

- Metrics tracked are specific to Bayou Health
- Metrics are reviewed real-time daily by our workforce management team, MSR supervisors and business managers within our member services center
- Compliance metrics are reported to DHH semi-annually and upon DHH request in compliance with Section 14.2.5.
- Metrics and metric drivers are reviewed daily for the first month post go-live in daily 'war room' meetings to ensure focus on meeting accurate customer care

Tools Used to Measure Member Services Performance

The following table describes the innovative tools we use to measure member services performance.

Compliance Metric Tools	
Goal	**Functionality**
Member Services Line	▪ Collect call type, program type, call center efficiency and customer satisfaction ▪ Monitor call response rate, real-time tracking of metrics

Compliance Metric Tools	
Workforce Management and Forecasting	▪ Record random sample of calls for quality review and document all quality review scores ▪ Track MSR performance metrics ▪ Use scheduling software to confirm all compliance metrics are met
Route Calls to Appropriate MSR	▪ Online routing system ▪ Inbound member calls routed by language, transfers and teleconference ▪ Interactive voice response (IVR) system
Member Satisfaction	▪ Collect member satisfaction and dissatisfaction feedback ▪ Automated survey option for members to participate; six questions that gauge their satisfaction with their experience
Overall Operational Monitoring	Network Operations Center monitors operations proactively 24 hours a day, seven days a week to confirm quick response to business continuity issues

We use a call monitoring system to conduct member services monitoring activities. These activities include performing evaluations, playing recordings, performing record on demand (instant recording) and live monitoring. Supervisors access the call monitoring system to review their team's quality evaluation details and scores. One hundred percent of calls are recorded, and we conduct quality reviews on a random sampling of calls that each MSR conducts. Our evaluation of customer service quality includes the following components:

- ***Phone Technique:*** Use a professional greeting to member, apply hold courtesy skills, apply call control skills, follow redirection procedures and use a professional closing at call end
- ***Building Trust:*** Identify member's inquiry or problem, demonstrate full attention to member, deliver response with confidence, communicate clearly and connect with the member
- ***Accuracy and Completeness:*** Provide accurate and complete information to the member
- ***First-call Resolution:*** Assure that call documentation matches the call content, route or close documentation correctly, make outbound call if necessary to resolve issue and send out requested information
- ***Education:*** Leverage member retention opportunities
- ***Policy Adherence:*** Verify member identification following HIPAA guidelines and internal policies, use internal terminology and proactively provide time frames and phone number

Workforce Management and Forecasting Actions

Our centralized Network Operations Center makes certain top-quality services are delivered across our member services center. The Network Operations Center uses sophisticated technologies that allow us to respond to unplanned call volumes by acting as a central source of information that identifies trends across all UnitedHealthcare operations and allows us to forecast and plan for our local member services center. For example, we anticipate when call volume is

Figure 41. National Operations Center. Technologies used within the National Operations Center ensure that we deliver quality responses to calls from our members in a timely manner.

high and staff accordingly. We maintain real-time reports on call queues and shift resources as needed to confirm optimal customer experiences that meet or exceed the required performance standards.

Our local management team uses a series of applications, including scheduling software, to aid in monitoring our call response rate on a daily basis, and generates specialized reports to identify peak call times while quantifying MSR productivity. In addition, our management team monitors the number of calls holding in queue to determine the longest wait time for any caller. This advanced technology helps us channel calls to the appropriate subject matter experts. The system offers a menu of automated and live MSR services. At any time during a call made during normal business hours, a member may opt, within the IVR, to speak with a MSR.

Workforce management and forecasting includes the following actions:

- Monitor and make real-time adjustments based upon intraday delivery of call volume
- Monitor real-time staff schedule adherence, comparing the MSR-assigned schedule to the actual schedule and communicate any disparities, real-time, to the supervisor for communication with the MSR
- Manage and maintain metric reporting: adherence, forecast to actual staffing, occupancy
- Maintain historical data for reporting, historical reference, planning and forecasting
- Monitor the system that tracks MSR performance metrics (e.g., average handle time, adherence, attendance, quality and member satisfaction) on daily, weekly and monthly benchmarks
- Manage scheduling software used to confirm appropriate staffing based upon forecast call volumes; real-time tracking of metrics provides ability to employ contingency plans quickly to maintain metric targets
- Meet with site leadership team weekly to discuss the staffing plan adjustments
- Determine capacity plans with input from DHH site leadership, operations control and executive leadership to confirm goals and adjust the business plan model as needed

Member Services Interactions with other Customer Service Lines

We have been serving Louisiana Medicaid members through a CCN-S contract since February 1, 2012, engaging with support services including city and parish agencies, culturally appropriate social service agencies, faith-based organizations, and consumer and family support groups where we can enlist additional services for our members.

To provide helpful interactions with other customer services lines, our MSRs must first:

- ***Listen:*** Our MSRs must employ active listening skills by paying full attention to what the member is saying.
- ***Identify needs:*** Once the MSR obtains all relevant information by listening to the member, they use their training, experience and resources to identify the member's specific needs.

- ***Locate solutions:*** After the member's needs are assessed, MSRs can use available internal resources to locate state, parish, city or community assistance.
- ***Engage resources:*** While the member is still on the call, the MSR discusses the recommended resources and, if needed, makes a three-way conference call to engage the resource and begin a dialog to obtain appropriate services.

Member services representatives interact with state, parish or city organization customer service lines by conducting three-way conference calls where they remain on the line to assist the member with the call, or a warm transfer, where they introduce the member and summarize their needs. If needed, the MSR can contact the customer service line on a separate call to get information or obtain a call-back for the member. The member is notified of the call outcome through a follow-up call from the MSR.

Our Bayou Health MSRs are provided with internal resources that include information on social services, agency referrals and other local and community support for members in need. Resources are updated frequently to ensure that the MSR provides prompt and accurate assistance.

After Hours Procedures

Bayou Health members who call our member services center after hours reach our IVR system, which provides them with the following transfer options:

- ***Direct Contact:*** Callers can be directly connected with the appropriate level of assistance, including the pharmacy line, through the toll-free telephone number. NurseLine is available 24 hours a day, seven days a week and staffed with RNs to address the member's questions and triage immediate health concerns. Nurse services include telephone crisis intervention, risk assessment and consultation with callers that may include family members and other community agencies seeking assistance with behavioral health issues. Intake coordinators may also provide referrals to community resources. Additionally, intake coordinators are trained to recognize the symptoms of a medical crisis, such as slurred speech, altered consciousness and shallow breathing.
- ***Behavioral Health Crisis Line:*** This line is answered by a mental health care professional. Community mental health centers staff crisis lines and connect members to follow up care, as needed.
- ***Option to leave a message:*** Callers are presented with the option to leave a message, provided with clear instructions on how to leave their message and when the message will be returned.

In compliance with Section 12.15.3, we will provide a voice mailbox with adequate capacity to receive all messages, pharmacy, member and provider, and return all messages by close of business on the next day.

NowClinic Acute Care

In addition to our member services line, we will provide Bayou Health members with telephonic access to NowClinic Acute Care. This service is available 24 hours a day, seven days a week to connect members with health care professionals by phone. Providers are locally contracted to educate members, as well as prescribe and diagnose. Members will speak with providers by

phone and share their symptoms. Health providers provide members with a diagnosis and a prescription, if necessary.

NowClinic is a valuable feature, providing care quality, ease of access and reduction in ER visits.

R.2 Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2014 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the abandonment rate. Affiliates should be included when determining the largest contract. (5 points)

Louisiana Member Services Telephone Reports

As a Louisiana CCN-S incumbent, we have provided our member services center telephone reports for the most recent four quarters as clarified in response to question 336 of Addendum #8. The reports show the monthly call volume, the trends for average speed of answer (reaching a live voice) and the monthly trends for call abandonment.

We are proud of the excellent service our call center has provided to our Bayou Health members since 2012. We look forward to continuing to serve our existing members and new members under this contract.

Louisiana Shared Services Contract		a. Volume	b. ASA	c. ABN
Q2	Jun-14	11,587	0.06	1.2
	May-14	11,650	0.05	0.7
	Apr-14	11,642	0.06	0.6
Q1	Mar-14	11,527	0.06	0.7
	Feb-14	11,192	0.08	0.8
	Jan-14	12,383	0.06	0.9
Q4	Dec-13	10,119	0.08	0.5
	Nov-13	9,843	0.08	0.5
	Oct-13	13,615	0.08	0.4
Q3	Sep-13	12,379	0.10	0.8
	Aug-13	12,727	0.12	0.83
	Jul-13	12,944	0.13	1.00

R.3 Describe the procedures a Member Services representative will follow to respond to the following situations:

- A member has received a bill for payment of covered services from a network provider or out-of-network provider;
- A member is unable to reach her PCP after normal business hours;
- A Member is having difficulty scheduling an appointment/finding a specialist.
- How do you explain to a member why a particular prescription is not covered? (10 points)

Member Services Procedures

We have created scenarios to describe the procedures Bayou Health MSRs use to assist members in the following situations:

Member received bill for payment of covered services from a network provider or out-of-network provider

Our providers should not bill Bayou Health members, but rather submit claims to UnitedHealthcare through our claims submission process. Providers are contractually prohibited from charging a copay or balance billing for services provided.

A provider submitted a bill to Julia, a Bayou Health member, for an office visit during which she was treated for a skin condition. Julia calls our Bayou Health member services center to discuss the bill.

- Julia is immediately connected to an MSR who establishes Julia's eligibility on the date of service and reviews claims information to determine if a claim was submitted and paid or not submitted.
- With Julia's eligibility established, the MSR assures Julia that she is not responsible for paying the bill and we will resolve the issue on her behalf.
- The MSR obtains pertinent information about the billing provider.
- After completing the call, the MSR reaches out to the provider relations staff who follows up with the provider to request that they no longer bill the member and then discuss methods of getting the claim to us or reviewing how the claim was paid. If needed, the provider is offered additional training or information on the claims submission process.
- Upon resolution, the MSR calls Julia to inform her of the outcome and recommends that she call back if she receives another bill.

Our strong provider education and training program provides ongoing general and targeted education to ensure all providers understand contract requirements, plan processes, claim submission and payment processes related to the Bayou Health program.

Member is unable to reach her PCP after normal business hours

Primary care providers are contractually required to provide after-hours telephone availability as described in Section 7.8.2 Primary Care Provider Responsibilities.

Maria, a Bayou Health member, is unable to reach her PCP after normal business hours for assistance with managing symptoms related to Crohn's Disease. When she cannot reach her PCP, she calls the member services center at 9:30 p.m.

- Maria is connected to an after-hours RN through NurseLine.
- The RN immediately begins assessing Maria's needs. Upon hearing the symptoms, the RN triages the call to determine appropriate response (e.g., physician on call, urgent care, ER) and documents the interaction.
- Because Maria's symptoms are not alarming or life threatening, the RN discusses various methods of symptom management with her and instructs her on what to do if the symptoms worsen.
- The RN advises Maria if the symptoms persist, she should call the PCP the next day to make an appointment to be seen by her doctor.
- After ensuring the member's health needs are addressed, the RN confirms the PCP information with Maria to ensure we have all the required follow-up information.

- The RN documents the call including the disposition of the member. This information is captured in a Daily Activity Report, which will be reviewed the following day by a clinical manager.
- After completing the call, the RN notifies the provider relations staff that a member experienced after-hours access issues with the PCP so that immediate follow up can be made.
- The provider relations staff follows up with the PCP to determine the appropriate action including education regarding the PCP's obligation to provide after-hours access for members.
- A clinical manager reviewing the Daily Activity Report on the following day sees the information about Maria's call and engages appropriate support as needed, such as a community health worker, to follow up with Maria and verify that she was able to access the care she needs.

We have processes in place to measure and verify compliance with after-hours coverage standards including member complaints, service coordinator feedback and regular audits. Ongoing noncompliance is expeditiously addressed by our network contracting team and, if necessary, by the Provider Advisory Committee (PAC), which may impose a corrective action plan and termination if necessary.

Member is having difficulty scheduling an appointment/finding a specialist

Our MSRs are trained and ready to assist members in locating a specialist who fits their needs, as well as scheduling appointments and arranging transportation to the appointment as needed.

Bayou Health member Caroline is working to gain control of her health by obtaining women's routine and preventive health care, including a physical, Pap smear and mammogram. She has made a few unsuccessful attempts to schedule an appointment with two known gynecologists in her area, but they are not accepting new patients. She calls the member services line to ask for help locating a female gynecologist in close proximity to her home.

- Caroline is immediately connected to a MSR.
- The MSR views Caroline's health history, and confirms that she is currently eligible for women's preventive health care services.
- The MSR verifies that Caroline has a PCP, who is a male family physician, but not a women's health specialist.
- The MSR, using her desktop tools, locates a female gynecologist within five miles of Caroline's home. She provides the location of the specialist and asks Caroline if she would like to schedule an appointment. Caroline agrees and the MSR makes a conference call with Caroline on the line.

  If the MSR had been unable to locate and make an appointment with an appropriate specialist, the MSR would have obtained the assistance of our case management team. If case management had also been unsuccessful in locating a specialist, our chief medical officer Dr. Logarbo would have become involved in locating the specialist.

- Once the appointment has been successfully scheduled, the MSR asks Caroline if she needs transportation to the appointment. Caroline indicates that her sister will transport her to the appointment.

Our member services model and well-trained MSRs provide a single call, full resolution member experience, saving time and providing high member satisfaction.

Explaining to a member why a particular prescription is not covered

Member services representatives have system tools available to determine the reason why a particular prescription is not covered. MSRs communicate the reason to the member and provide additional assistance.

Patrick, a Bayou Health member, suffers from seasonal allergies which sometimes cause asthma symptoms. Although Patrick keeps an emergency inhaler with him, his doctor periodically prescribes a preventive asthma medication to help during certain seasons. When Patrick visited his pharmacy to drop off his new prescription, he was told that the medication is not covered. He calls the member services line to ask why his prescription cannot be filled.

- Patrick is immediately connected to a MSR.
- The MSR asks for the name of the medication and checks the current formulary.
- The MSR observes that the medication is not covered and offers to call the physician to assist in obtaining a new prescription from the current formulary.
- On the call, the physician's office agrees to make a change to the prescription and call in the new prescription to Patrick's pharmacy.
- The MSR follows up with Patrick and the pharmacy to advise them of the resolution.

Prescription coverage issues may be caused by the following:

- The medication may not be covered because it is not a part of the member's current benefit or is not on the current formulary/preferred drug list (PDL). In this situation, MSRs can contact the member's PCP to ask for a prescription from the current formulary/PDL.

  In addition, the MSR can contact provider relations and suggest provider education regarding the formulary. Our provider advocates in the field make providers aware of the various ways to access the PDL and how and when to access the provider call center. Prescriber training on the pharmacy benefit will also be included in our initial provider training, our *Provider Administrative Guide* and other provider materials developed by UnitedHealthcare. Formulary information is also readily available on BayouCloud, our provider portal. Our pharmacy team will work closely with our network team to assure pharmacy is incorporated into their materials.
- If the system indicates the member is on the pharmacy lock-in program, there are certain restrictions placed on where the member can obtain and fill prescriptions.
- Special circumstances may apply to transitional members. Through the transition of care program:
  - New members can continue receiving maintenance medications for at least 60 days after the launch of pharmacy services or enrollment

  - Treatment of antidepressants and antipsychotics for new members is continued for at least 60 days after enrollment
  - Members receiving a prescription drug that is not on the formulary/PDL can continue to receive the prescription if medically necessary for at least 60 days
- Other special circumstances include:
  - Medication prescribed to a member in a state mental health treatment facility is continued for at least 60 days after facility discharge, unless it is determined by our psychiatrist in consultation and agreement with the facility's prescribing physician determine that the medications are not medically necessary or potentially harmful to the member.

Members receiving a prescription drug that was on the formulary/PDL and subsequently removed or changed are permitted to continue to receive the prescription drug if determined to be medically necessary for at least 60 days (determination to be made in consultation with the prescriber).

Section S: Member Grievances and Appeals

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

- Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal;
- Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and
- Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary.

Include in the description how data resulting from the grievance system will be used to improve your operational performance. (10 points)

We agree to comply with each specification and requirement outlined in Section 13.0 Member Grievance and Appeals Procedures.

In 2013, each of the five Bayou Health plans was audited separately by an External Quality Review Organization (EQRO). The EQRO audit assessed UnitedHealthcare as fully or substantially compliant with 643 of 648 items or more than 99 percent full and substantial compliance – ***higher than other health plans in the State***.

Since 2012, under the leadership of our Louisiana-based grievance system manager Coudra Costict, we have operated a member grievance and state fair hearing system that provides members with a voice in decisions that affect them personally. Our system complies with 100 percent of the State of Louisiana's (State's) member grievance and state fair hearing requirements. In the first two quarters of 2014, we received and resolved 136 member grievances; participated in 15 state fair hearing requests; and reversed our decision in a member's favor through the state fair hearing process six times. Since program inception, the Division of Administrative Law (DAL) has only overturned one UnitedHealthcare decision as a result of a state fair hearing review.

Because we do not process member appeals today, we will expand our current member grievance and state fair hearing system to accept and process member appeals using systems and processes currently in use in Louisiana and by leveraging our national member grievances and appeals best practices based on 32 years of Medicaid experience and the 4.8 million Medicaid members we serve today.

The 2013 EQRO audit assessed our member grievances and appeals system as fully or substantially compliant with all 52 requirements (49 fully compliant and three substantially compliant).

We have implemented detailed written processes and procedures to regulate receiving, tracking, responding to, reviewing, reporting and resolving grievances and appeals. We view each individual grievance and appeal as an opportunity to improve the care and services we provide to the members who file them. Additionally, member grievances and appeals represent a means of understanding trends that allow us to make continual improvements to the way we provide care and services, thereby reducing the number of grievances and appeals filed.

Our member grievance and appeals system complies with 42 CFR, Part 438, Subpart F, all applicable federal and state laws, regulations and policies and the requirements in Section 13.0. We submitted our grievances and state fair hearings policies and procedures to DHH for approval in 2012. We will submit our member grievances, appeals and state fair hearings policies and procedure to DHH for approval.

Our 24 grievances and appeals staff is based in Louisiana supported by five national staff.

Under the leadership of Ms. Costict, our qualified and trained Louisiana-based grievance and appeals staff maintains structured member grievances, member appeals and state fair hearing processes, which afford members recourse for having their issues addressed in a professional, consistent and timely manner. Our approach is based upon written policies and procedures that outline the grievance system process for members, subcontractors and non-contracted providers, defining their rights regarding any disputes they may have with UnitedHealthcare.

Minimizing Barriers to Members and Providers

In accordance with Section 13.2.4.2., we inform members about our easy-to-use grievance, appeal and state fair hearing policies and procedures, which comply with the due process requirements set forth by the State and federal requirements. Upon enrollment, our members receive oral and written information regarding our grievance system, including pertinent policies and procedures and specific details on filing grievances, appeals and state fair hearings (e.g., the right to file grievances, appeals and claim disputes and the requirements and timeframes for filing them).

We provide this information in the member's welcome packet, on their ID card, in our *Member Handbook* and our member website, *myuhc.com*. We also include this information in the Notice of Action and the Notice of Appeal Resolution we send to members. We send our members an annual reminder about grievance and appeals system processes and their right to use these processes. Upon securing a contract, we give this information to network providers in our *Provider Administrative Guide* and annually through our quarterly newsletter, *Practice Matters*, and on our provider website. We inform members and providers of significant changes to appeals and grievances-related processes prior to the effective date.

Member advocates reach out to members regarding grievances to clarify the grievance and what the member needs or expects from the grievance.

Member advocates review each appeal for additional information the member may want to provide to help with his or her appeal. They research the members profile for information, such as additional insurance and past authorizations, before the member's appeal date.

Member advocates call each member to ask if they will be appearing at the appeal in person or via telephone and asks if there is anyone the member would like to participate in the appeal.

Detailed instructions for filing a grievance or appeal include a toll-free number (shown on the member's ID card) for accessing our member services center. Non-English-speaking members can access our member services center through Language Line interpretive services, which are available free of charge. A member who is hard of hearing can use our toll-free telecommunications relay service and members with impaired vision can request that a member services representative (MSR) read the materials aloud.

We encourage members who have an inquiry or complaint to call our member services center. MSRs will work with the

member to resolve the issue to the member's satisfaction on the phone. If unable, the MSR can assist the member with the grievance and appeals process, including preparing and submitting a written complaint or grievance. Additionally, care managers, member advocates, community health workers and our quality team help members write and file grievances and appeals and will continue monitoring the member's issue through to resolution. This commitment creates an environment where members view us as a resource and affords us the opportunity to resolve member issues with as little dissatisfaction as possible.

Grievances and Appeals Process

We have presented our structured member grievances and appeals process in the figure below and state fair hearing process (the second figure, below) in Chart C. These processes give members recourse for having their issues addressed in a professional, consistent and timely manner.

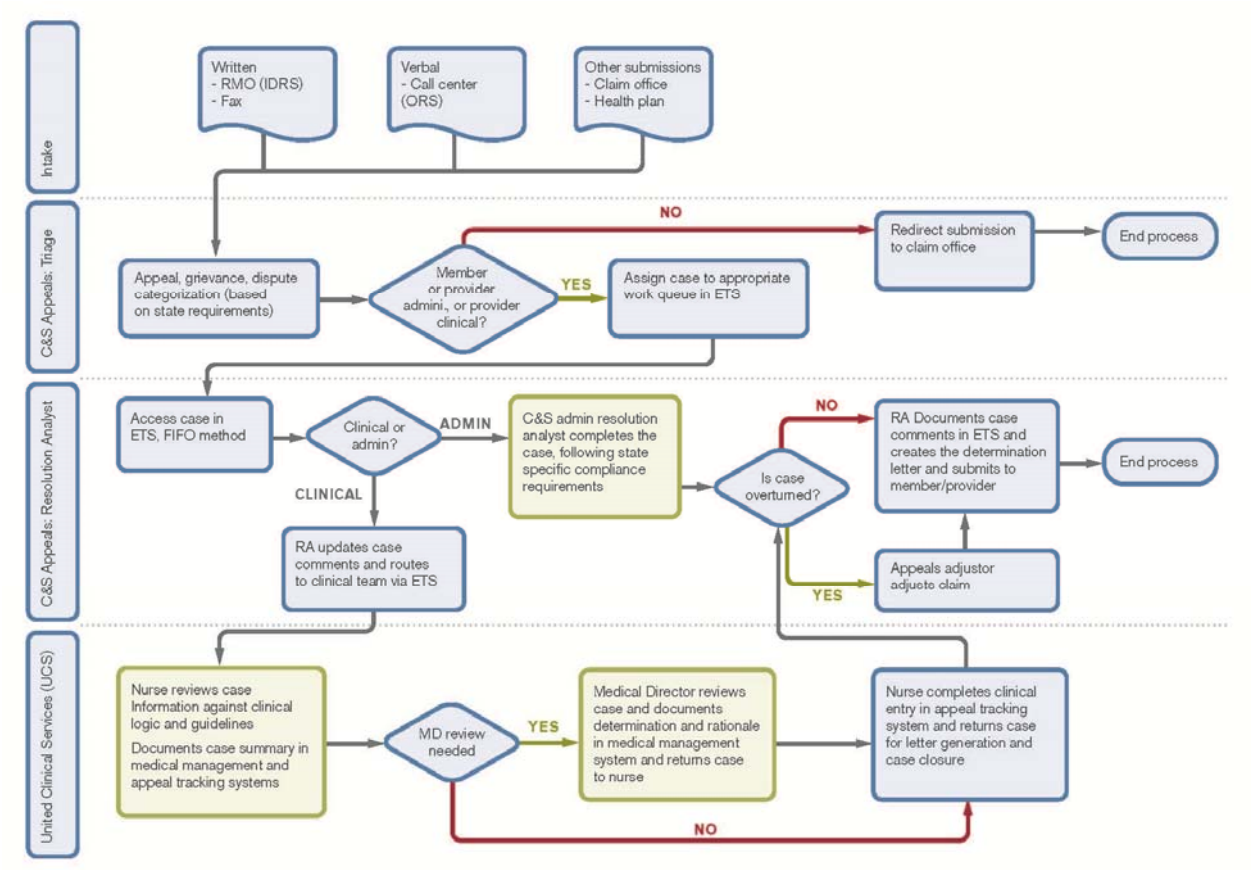


Figure 42. Chart C: Member Grievances and Appeals Process. Our comprehensive member grievance and appeal process affords our providers recourse for having issues addressed, documented, investigated and resolved in a professional, timely, consistent and uniform manner. Member grievances and appeals provide us with an opportunity to improve the care and services we provide to the members who file them.

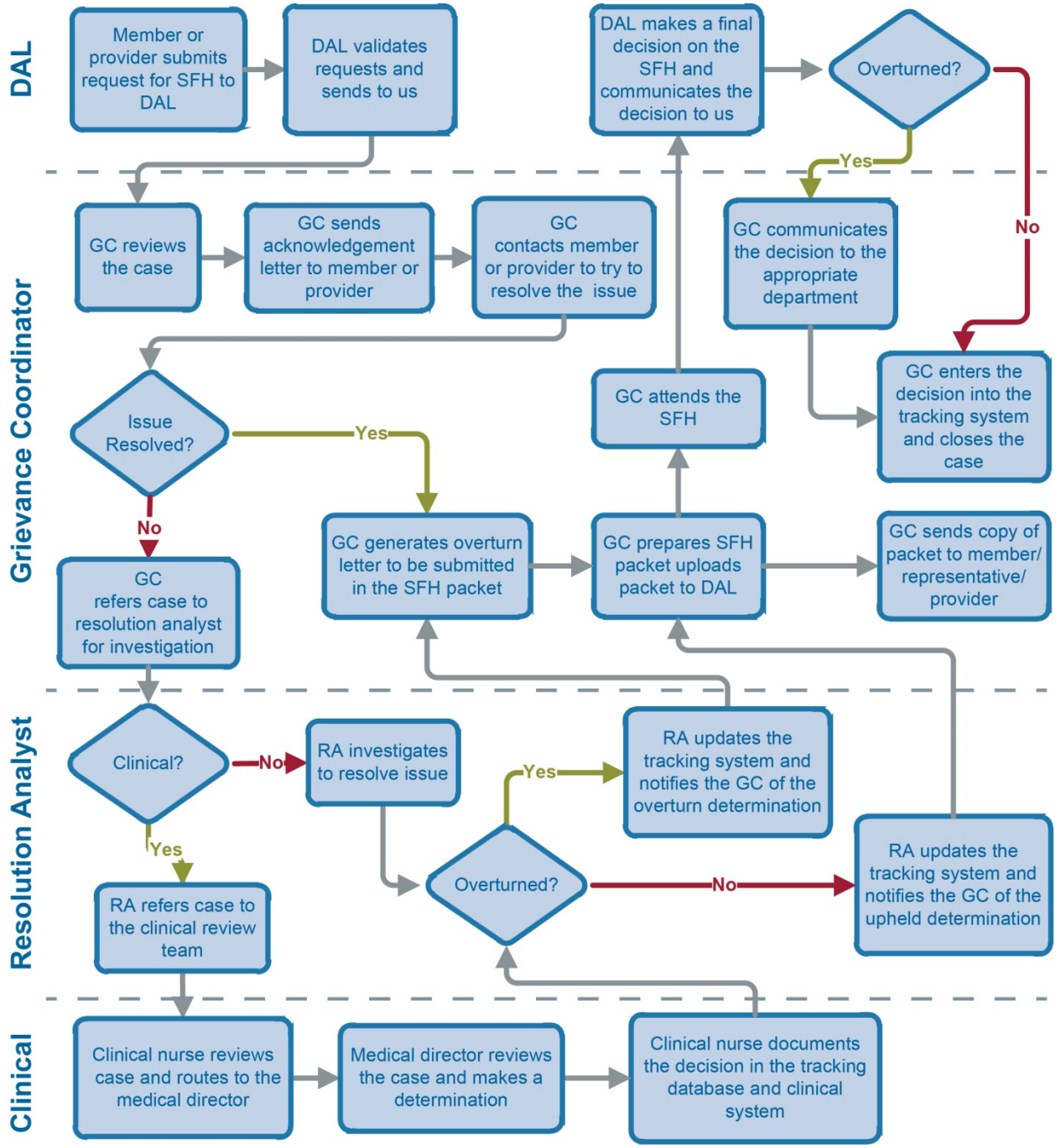


Figure 43. Chart C: State Fair Hearing Process. Through our state fair hearing process, we investigate the member's state fair hearing request to affirm or overturn our decision and attend the DAL state fair hearing to receive a final disposition of our appeal resolution.

Ensuring Quality Performance

As described later in this section, our quality management (QM) department collaborates with our appeals and grievance team, compliance department, and member services department to collect, review, analyze and trend grievances and appeals data from our grievances and appeals tracking system to assess member satisfaction and to identify opportunities for improving the member experience. Data analysis also helps the QM department analyze trends necessitating

further evaluation and education. These analyses are presented to QM leadership and the overall process is evaluated for review of aggregate trends and identification of actions for improvement. Improvement actions may include additional education for staff or providers, a change in our policies or procedures or data system enhancements. We also provide grievance and appeals data to our Provider Advisory Committee (PAC) when resolving quality of care issues.

Grievances and Appeals Tracking System and Reporting

Using our grievance and appeals tracking system, our staff maintains, records and stores all grievance and appeals activity, including policy-mandated time frames for member contact and appeal or grievance resolution. Our grievance and appeals tracking system security protocols allow staff and managers at various levels and departments to have read, write or update permissions to individual grievance and appeals tracking system data elements and modules. Our grievance and appeals tracking system allows staff to identify open, outstanding or priority grievances requiring resolution and to query and review a specific member's grievance history. Using our grievance and appeals tracking system, we track and report data related to grievances and appeals in compliance with NCQA, reporting for accreditation purposes in quality of care; access; attitude and service; billing and financial issues; and quality of practitioner office site.

Filing Member Grievances and Appeals

We accept member appeals and grievances in compliance with the requirements in Sections 13.2.2, 13.2.3 and 13.2.4 as described in the following sections.

Filing a Member Grievance

Any member, his or her authorized representative or a provider acting on behalf of the member, with written permission from the member, may file a grievance with UnitedHealthcare by calling our member services call center or by mailing a grievance to us. The grievance must be filed within 30 calendar days from the date of our Notice of Action.

We enter written (date-stamped upon receipt) and verbal grievances into our grievance and appeals tracking system on the date of receipt and create a case file. Using our grievance and appeals tracking system, we log and track member name and identification number, date grievance received and grievance acknowledgement, grievance description, staff assigned for disposition, disposition, disposition date and member notification date. We capture additional information, such as date of resolution, description of resolution, and whether the grievance was determined valid.

If a member files a grievance orally, acknowledgement of receipt is understood. We acknowledge receipt of written member grievances in writing within five business days, unless the member or provider requests an expedited resolution. No punitive action will be taken against a provider who files a grievance on behalf of a member or supports a member's grievance.

Filing a Member Appeal

If a member receives a Notice of Action, he or she has the right to appeal. An action is any denial, limitation, reduction, suspension or termination of service, denial of payment or failure to act in a timely manner. We will accept appeals in writing or verbally via member services and treat oral inquiries seeking to appeal an action as appeals. A member or member's authorized representative, including their provider with written member consent, may file an appeal on behalf of the member. The appeal must be filed within 30 calendar days from the date of our

Notice of Action. Except for expedited appeals, the phone appeal must be followed in writing within 10 calendar days of the call. We acknowledge the receipt of an appeal in writing within five business days, unless an expedited resolution is requested. No punitive action is taken against a provider who supports a member's appeal or requests an expedited resolution.

Resolving a Member Grievance or Appeal

We handle member grievances and appeals in accordance with Section 13.4. We date stamp the grievance or appeal and triage the request to assure all requests for appeals, grievances, inquiries and complaints are identified, investigated, resolved, tracked, and filed according to all federal and State requirements. During triage, we determine:

- If more than one member, provider or authorization is indicated. If so, this may require more than one case to be created in our grievances and appeals tracking system.
- The type of issue (e.g., request for member appeal or state fair hearing, member balance billing issue).
- Issue priority (e.g., standard or expedited).
- Issue category (e.g., appeal related to medical benefits, behavioral health, dental, quality of care/quality of service).

Once we have triaged the request, we log the grievance or appeal into our grievance and appeals tracking system to track the appeal or grievance and ensure prompt resolution, including adherence to all contract requirements. Our grievance and appeals tracking system generates an acknowledgement letter, which is sent to the member acknowledging the grievance or appeal. Our grievance and appeals tracking system then queues the grievance or appeal to a resolution analyst (RA) for investigation and resolution.

The RA provides each member or member's representative a reasonable opportunity to present evidence and allegations of fact or law in-person and in-writing. The RA informs the member or the member's representative of the limited time available in cases involving expedited resolution. We date stamp and incorporate into the case file any information received during the resolution process. We provide members an opportunity to examine the grievance or appeal file, including medical records and other documents considered by UnitedHealthcare during the resolution process.

Member advocates contact members to give them our appeal committee's decision. When appeals are upheld, the committee often makes recommendations to meet the member's needs in lieu of the denied services. For example, in our Delaware health plan, a member was seeking a nutritional supplement to maintain her weight, but the supplement did not fall under the guidelines. During the appeal, we determined that the member would benefit from a nutritionist and approved nutritionist services.

Resolution analysts have excellent communication skills, strong written and verbal skills, sound deductive reasoning skills and extensive knowledge of federal and state laws, regulations and policies. They use these skills to provide prompt resolution of the member's grievance or appeal, including investigating all pertinent facts related to resolving the grievance or appeal. Unless the grievance or appeal involves a denial based upon lack of medical necessity or otherwise involves clinical issues, the RA researches and adjudicates the grievance or appeal. The RA may enlist the help of other UnitedHealthcare departments if subject matter expertise is needed.

If the matter requires review by another UnitedHealthcare department, such as clinical, the RA requests that a designated subject matter expert in the department address specific issues necessary to resolve the appeal. The RA may contact the member or the member's treating provider to obtain additional information necessary to resolve the grievance or appeal.

For clinical appeals, the RA assembles relevant background information from our prior authorization and claims systems, obtains relevant clinical information and forwards the matter to a medical director or other health care professional to review the matter. Only medical directors or other health care professionals with the appropriate clinical expertise, and those not involved in previous levels of review or decision making, review appeals.

Upon completion of this process, the RA issues a written Notice of Appeal Resolution. In the case of an expedited appeal, the RA also provides verbal notice of our decision. We issue a written Notice of Appeal Resolution for both expedited and standard appeals resolutions and a Notice of Disposition for grievances.

Timelines for Resolving Grievances and Appeals

We resolve grievances and appeals within the timeframes required in Sections 13.6.1 and 13.6.2 (e.g., resolving grievances with 90 days from the day we receive the grievance). If we receive the grievance or appeal in writing, the resolution timeframe begins from the day we receive the written grievance or appeal. If we receive the grievance or appeal verbally (followed by written notice), the resolution timeframe begins from the day we receive the written grievance or appeal. We may extend the resolution timelines for either expedited or standard appeals on the request of the member or if we need additional information and the extra time needed to obtain the information is in the member's best interest. We may request an extension of up to 14 days and will provide the member with a written notice of the extension and the reasons for the delay.

For appeals of an action, we resolve and notify the member as quickly as possible, but not longer than contractually required turnaround times. Only medical directors with the appropriate clinical expertise and not involved in previous levels of review or decision making, review appeals. We review the appeal and notify the member of the resolution no later than 30 days after we receive the request, unless an extension is effect.

We process requests for expedited appeals following our expedited appeal resolution process, presented later in this section.

Continuing Member Benefits

We will continue member benefits until a decision is rendered in accordance with 42 CFR 438.420 and Section 13.8. Members, or providers with the member's written permission, can ask that an appealed service continue while we are making a decision. The member, or the member's representative, must make the request within 10 days from the date we mail the notice of the adverse action or within 10 days after the intended effective date of action, whichever is later. The appeal must be for the termination, suspension or reduction of a service we have already authorized, ordered by an authorized provider, before the original authorization has expired. If the member does not win the appeal, he or she may have to pay for these services.

Coordinating Adverse Actions with DHH

We have experience working with DHH to provide information on adverse decisions for further review or action when requested. Our contract compliance coordinator Larry Smith responds to

DHH requests by coordinating with Ms. Costict and other personnel within our organization, as needed, to promptly provide DHH with whatever information they require regarding adverse decisions. We will continue to work with DHH regarding any recommendations about the resolution of a member grievance or appeal.

Communicating Actions to Members

Notice of Disposition. We communicate the disposition of a grievance in compliance with Section 13.6.3. We send a written Notice of Disposition to the member to explain what actions we took to investigate and resolve a member grievance and the final outcome.

Notice of Appeal Resolution. The Notice of Appeal Resolution contains the results of the appeal resolution process, including the legal citations or authorities supporting the determination, along with the date it was completed. The Notice of Appeal Resolution will be in compliance with Section 13.6.4. The Notice of Appeal Resolution is sent via certified mail within the applicable resolution timelines. We make reasonable efforts to provide verbal notice to a member regarding an expedited appeal resolution.

Notice of Action. The timing and content of our Notice of Action complies with Sections 13.5.2 and 13.5.3 and meets the language and format requirements of Sections 13.5.1, 42 CFR §438.10(c) and (d) and Section 12.0. We provide Notices of Action in Spanish and Vietnamese and will translate Notices of Action upon request.

Grievance and Appeal Record Retention

In accordance with Section 13.3.1, our grievance and appeals tracking system maintains a copy of grievance logs and records of disposition of appeals for six years. For any documents involving litigation, claim negotiation, audit or other action, we will retain the records until completion of the action and resolution of issues which arise from it or until the end of the regular six year period, whichever is later.

Grievance and Appeal Reporting

We provide and will continue to provide monthly reports to DHH in accordance with the format, timelines and conditions in Section 13.3.2. We report and will continue to report any adverse actions to DHH for further review or action upon request by DHH or our member as required by Section 13.3.3.

State Fair Hearings

We communicate information about, process and participate in state fair hearings in compliance with Sections 13.4.6 and 13.6.5. For appeals not resolved wholly in favor of the member, we communicate the following information in the Notice of Appeal Resolution to the member regarding state fair hearings:

- The member's right to request a state fair hearing, including the requirement that the member must file a written request for a state fairing within 30 calendar days from the date of the Notice of Appeal Resolution
- How to request a state fair hearing, including continuation of benefits

Since program inception, the State has only overturned one UnitedHealthcare decision as a result of a state fair hearing review. In the first two quarters of 2014 we participated in 15 state fair hearing requests and reversed our decision in a member's favor through the state fair hearing process six times.

Once a member has filed a state fair hearing request with the DAL, DAL forwards the member's state fair hearing request to Ms. Costict, who is responsible for coordinating the investigation of the state fair hearing request, preparing the state fair hearing packet for DAL and attending the state fair hearing. If the member submits the request to us, Ms. Costict forwards the request to DAL. Upon receipt of DAL's notification of the member's request for a state fair hearing, we:

- Send an acknowledgement letter to DAL and the member.
- Contact the member to try to resolve the issue. If we are able to resolve the issue, we submit the reversal decision to DAL and send the member a copy of our reversal decision.
- If we are unable to resolve the issue, we investigate the state fair hearing, including coordinating with the appropriate department (e.g., claims or clinical) for review and confirmation of our decision.
- If we reverse our decision as a result of our review, we submit the reversal decision to DAL and send the member a copy of our reversal decision.
- If we do not reverse our decision as a result of our review, we prepare the state fair hearing packet for DAL, which includes a cover memorandum, summary of evidence and supporting documentation, and upload the state fair hearing packet to the DAL website.
- Attend the state fair hearing set by DAL. Additional UnitedHealthcare attendees may attend the hearing as needed. We acknowledge that an administrative law judge at DAL conducts the state fair hearing. Upon making a determination, DAL will notify us, the member and DHH of its decision.
- If DAL overturns our decision, we notify the affected UnitedHealthcare departments to ensure the member receives the services and provider claims for services are paid properly and timely. For example, our clinical team will update our CareOne system to ensure services are authorized for the member in accordance with DAL's decision.
- Following the state fair hearing, we update our grievances and appeals tracking system with the date and final disposition of each appeal and close the case file, retaining the data for six years.

In addition to our grievances and appeals staff, we provide grievances and appeals training to all members of our staff (e.g., MSRs, community health workers, care managers) so that they understand the member grievances and appeals process and can help members work through the grievances and appeals system.

Staff Training

Every member of our Louisiana-based grievances and appeals staff undergoes intensive member grievances and appeals and Louisiana-specific training. This includes, but is not limited to, the usual and customary new employee orientation as well as ongoing mandatory training, including job specific updates, policy change processes/workflow and the maintenance of job specific performance standards. New and existing grievances and appeals staff is trained in the geography of Louisiana as well as culture and correct pronunciation of cities, towns and family surnames.

In new hire training and annually thereafter, we educate grievances and appeals staff on the importance of the grievance and appeal procedures, the rights of the member and providers, a summary of our quality management program, critical thinking, compliance with HIPAA, the concepts of member grievance, appeals and the state fair hearing process and using our

grievances and appeals tracking system to manage member grievances and appeals from receipt through to resolution. We expose grievances and appeals staff members to their role in the member grievance, appeals and state fair hearings process (e.g., working with other UnitedHealthcare departments to research and resolve a member grievance or appeal) and provide training on Louisiana-specific policies that require adherence, such as filing and resolution timelines and required communications to members and providers.

Ensuring Primary Language and Providing Reasonable Assistance

We are committed to responding to member and provider concerns to resolve issues at the earliest opportunity. At every contact, we are responsive and offer assistance to our members and providers in any way we can as required in Section 13.4.1.2. Assistance begins by informing members about our easy-to-use grievance and appeal procedures upon enrollment. We provide information (e.g., member's welcome packet, on their ID card) about our grievances and appeals system to members in Spanish and Vietnamese and will translate member materials upon request. We also provide Notices of Action in Spanish and Vietnamese and will translate Notices of Action upon request.

When calls are placed to our member services center, we serve members in their choice of primary language. Many of our MSRs are bilingual and all MSRs have access to Language Line interpretive services, which provide translators for more than 170 languages, as needed. A member who is hard of hearing can use our toll-free telecommunications relay service and members with impaired vision can request that an MSR read the materials aloud.

We encourage members who have an inquiry or complaint to call our member services center. MSRs will work with the member to resolve the issue to the member's satisfaction on the phone. To address issues that rise to the level of grievance or appeal, we offer help and guidance to our members and providers at every level of the grievance and appeals process. For example, all written materials sent to members and providers give simple instructions on how to access the next level of grievance or appeal.

Additionally, care managers, community health workers, member advocates and our quality management team help members write and file complaints and appeals and monitor the member's issue through to resolution. This commitment creates an environment where members view us as a resource and affords us the opportunity to resolve member issues with as little dissatisfaction as possible.

Appropriate Expertise to Make Grievance and Appeals Decisions

All grievances and appeals are investigated and resolved by UnitedHealthcare staff in compliance with Section 13.4.1.3. Clinical nurses ensure that individuals completing reviews of grievances and appeals were not involved in previous levels of review or decision making. All health care professionals have appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease.

We may consult with or seek the participation of additional medical experts as part of the appeal resolution process with the member's consent. These health care professionals will make decisions regarding an appeal of a denial that is based upon lack of medical necessity; a grievance regarding denial of expedited resolution of an appeal; or a grievance or appeal that involves clinical issues.

Determining When the Expedited Process is Necessary

Expedited appeals require a faster review because the timeframes for a standard resolution may seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. Our expedited review and resolution of appeals process complies with Section 13.7 and includes the following steps:

- A member, or provider acting on the member's behalf, requests an expedited appeal by calling our member services center.
- We forward the expedited appeal request to a medical director to determine if the request meets the criteria for expedited appeal.
- Our medical director reviews the expedited appeal request. We will expedite resolution of an appeal if, according to the information provided by the member or as indicated by a provider filing an appeal on the member's behalf, the standard resolution timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.
- If our medical director determines the expedited appeal does not meet the criteria for expedited appeal, we make every effort to contact the member and provide prompt verbal notice of our decision within two days, followed by a written notice of denial of expedited resolution that explains that we will transfer the appeal to our standard appeal process and informs the member of their right to file a grievance in response to our decision.
- If our medical director determines the expedited appeal does meet the criteria for expedited appeal:
  - The expedited appeal is queued to our RA for investigation and resolution.
  - The RA adjudicates the expedited appeal following our standard appeals resolution processes and procedures, such as forwarding clinical appeals to the clinical team for review of the matter, ensuring that we resolve the appeal and communicate our determination within 72 hours.
  - We provide verbal notice of our decision within 72 hours and issue a written Notice of Appeal resolution. The Notice of Appeal resolution contains the results of the resolution process, including the legal citations or authorities supporting the determination along with the date it was completed.

Using Data to Improve Operational Performance

Our QM department is the central area for receiving potential quality/risk management issues and coordination of quality improvement activities. It serves as a critical interface between members, members' representatives, practitioners, providers, the State and other regulators and various UnitedHealthcare departments, such as grievances and appeals, utilization management and clinical management, to identify opportunities for operational improvement and to implement appropriate interventions.

Our QM department collects, reviews, analyzes and trends grievances and appeals data to assess member satisfaction and to identify opportunities for improving the member experience. Data analysis also helps the QM department analyze trends necessitating further evaluation and education. These analyses are presented to QM leadership and the overall process is evaluated for review of aggregate trends and identification of actions for improvement. Improvement

actions may include additional education for staff or providers, a change in our policies or procedures or data system enhancements.

Grievance System Tracking and Reporting

We use our grievance and appeals tracking system to log all member issues, including complaints, grievances and appeals, which allows us to perform tracking and trending activities. We track and report data related to grievances and appeals in compliance with NCQA, reporting for accreditation purposes in quality of care; access; attitude and service; billing and financial issues; and quality of practitioner office site. This allows us to identify opportunities for improvement and to implement appropriate interventions.

The following table provides key grievances and appeals data elements that are maintained in our grievance and appeals tracking system and can be used for tracking, trending and reporting.

Key Grievance and Appeals Tracking System Grievance and Appeals Data	
Member Grievances	**Member Appeals**
▪ Date grievance was received ▪ Individual filing the grievance ▪ Member identification information ▪ Individual recording the grievance ▪ Nature of the grievance ▪ Disposition of the grievance ▪ Corrective action required ▪ Priority status (expedited status) ▪ Staff assigned for disposition ▪ Date of resolution and the member notification of the disposition ▪ Date the Notice of Action was sent	▪ Effective date of the action ▪ Date the member or representative requested the appeal ▪ Identification of the individual filing ▪ Member identification information ▪ Date the appeal was followed up in writing ▪ Nature of the appeal ▪ Disposition of the appeal ▪ Priority status (expedited status) ▪ Staff assigned for disposition ▪ Date of resolution and member notification of disposition

Trending and Analyzing Grievances and Appeals Performance

Our QM department collaborates with our compliance department and member services team to track and trend cases, conduct analysis of root causes and develop improvement activities based upon findings. We pull aggregate data for reporting and completing quantitative and qualitative analysis. We incorporate the grievance and appeals system data in decision-making activities to refine our operational process and to enhance the quality of our service delivery. We analyze data on a daily, weekly, monthly or ad hoc basis.

Each quarter, our Quality Management Committee (QMC), Service Quality Improvement Subcommittee (SQIS), Provider Advisory Committee (PAC) and Healthcare Quality Utilization Management (HQUM) subcommittee review the analyses and:

- Establish goals and performance thresholds and compare results to previous measurement
- Conduct root cause analysis and barrier assessments to provide insight into issues that may have contributed to the causes and performance gaps in achieving established goals
- Develop and implement action plans, taking into consideration member dissatisfaction and any disruption to the access of appropriate health services
- Incorporate the data analyses in decision making activities to refine our operational process and to enhance the quality of our service delivery

- Leverage national subject matter experts to review the analyses, identify contributing factors and drive policy and procedure changes and interventions to address systemic issues, barriers or other opportunities to improve processes, outcomes and member satisfaction

In addition, we analyze trend data in our annual program evaluation, which drives quality improvement recommendations in various operational areas based upon year-over-year data.

Examples of Using Grievance and Appeal Information to Improve Quality

In each of the 23 state Medicaid programs we serve nationally, our systems, processes and organizational structure (e.g., collaboration between grievances and appeals, compliance and QM through quality committees) allow us to track our handling and resolution of member and provider grievances and appeals so that we can ensure our compliance with contract requirements and continue to provide high-quality services to our members and providers. We will bring to Louisiana these established systems, processes and organizational structure to evaluate grievances and appeals data and act on issues we identify.

Some examples from Louisiana and other states where we have implemented similar member grievance and appeals systems include:

- In Louisiana, an analysis of member grievances indicated a significant increase (2013 versus 2012) in member grievances related to providers' balance billing members. We also determined that 77 percent of member grievances were related to this issue. To reduce the number of member grievances related to provider balance billing, we sent educational materials to each provider that balance bills members reminding them that members do not have a financial liability if they see a Medicaid provider and the service provided is a covered benefit. Additionally, we have deployed provider advocates to assist providers with correct coding, billing procedures and billing issue resolution.
- In Delaware, our prior authorization denials for services provided by "blind" providers (e.g., anesthesiologists) were being appealed and overturned at a higher rate. We conducted an analysis and determined that our claims system was denying claims submitted by these providers because the prior authorization for the services had been denied. These providers are out of network, but their services do not require prior authorization when they are related to another service (e.g., surgery) and the provider performing that service is in network. As a result, we created a process to ensure payment to these out-of-network providers for their support of authorized services and developed a macro to override the prior authorization denials if a claim has not hit the check run and a monthly report to identify claims that already hit the check run so those claims could be adjusted.
- In Maryland, we trended a significant increase in provider appeals related to two claim codes. We also noticed an increase to the State's overturn rate of our appeals related to these claim codes. We conducted a root cause analysis and determined that our claims processing system was incorrectly denying these claims. Through a redesign of the auto pay list, a restructuring of the appeal versus claim review process and improving the process to review appeals, we drastically reduced the appeal volume for issues related to these claims codes.

Part VI: Marketing & Member Materials

Section T: Marketing and Member Materials

T.1 Describe proposed content for your member educational and marketing materials and attach examples used with Medicaid or CHIP populations in other states. Describe innovative ways that you have engaged in member education. Describe how you will provide equitable marketing throughout the state.

Provide examples or descriptions of how your member education and marketing materials will be used to improve service coordination including:

- The coordination of carved out and behavioral health services.
- Supporting MCO efforts toward EPSDT compliance, appropriate ED utilization, STI education, encouraging the use of prenatal services and prematurity prevention
- The use of technological tools, including social media and mobile technology, to engage members.
- Partnering with community-based organizations for education and outreach. (20 points)

We will continue to build upon our current experience and knowledge of Bayou Health members and their families in developing educational and marketing materials and will comply with each specification and requirement outlined in Section 12.0.

Proposed Content for Member Educational and Marketing Materials

As the State's largest Medicaid managed care provider, we created successful, culturally competent marketing and member materials to reach and educate the Bayou Health population. Our member materials are designed to help present and future Bayou Health members understand their covered health care services and how to access them as quickly as possible. We also provide materials to assist members in locating providers, managing chronic illnesses and understanding the importance of preventive health care. Our materials are designed to be easily understood and are available in foreign languages and for members with special needs.

Providing Materials that are Easily Understood

Member materials are written at no higher than a 6.9-grade reading level where terminology permits (e.g., certain medical terms may be higher than a 6.9-grade reading level). We also regularly review and update member materials to comply with any required reading-level changes in the program and include feedback from members to customize materials to Louisiana-specific program requirements. Updated member materials will be distributed only after State review and approval in compliance with Section 12.0.

Based on our *Just Plain Clear* initiative, we use our proprietary Doc Scrub Readability tool to assure materials are at or below a 6.9 grade reading level. This tool rates and confirms that the materials we produce are easy to read, understand and act upon, and that they present information in a manner that most members can easily understand.

The Doc Scrub database, based upon the Flesch-Kincaid reading level tool, was designed to check the reading level of a created document and highlight areas where the reading level is higher than recommended. The tool scans the document and provides us with details such as word count and readability. It notates the reading level and highlights words or sentences that give the document a higher-than-recommended reading level. Upon reviewing the tool's

suggestions, we make necessary changes and the tool updates and displays the new reading level of the document.

Providing Written Materials for Members with Special Needs

For our members with cognitive deficits related to either disease states (e.g., Alzheimer's) or mental illness (e.g., depression, schizophrenia), our member services representatives (MSRs) are trained to assist the member using empathetic listening and when necessary, engage the assistance of a care coordinator for in-person member assistance.

For members with specialized visual requirements, we provide materials in Braille, large print, voice recorded CD formats or verbal explanations.

Providing Written Materials for Non-English Speaking Members

The DHH-approved customized member materials are available in English, Spanish and Vietnamese and will be available upon approval of DHH in other languages, as required. We also provide language translation services for a wide variety of additional languages upon request. If enrollment, or potential enrollment, reaches at least 4 percent for another non-English speaking group, materials will be published in those languages. Primary language data are collected during enrollment and health risk assessment (HRA) to help us identify the need for written materials in other languages. We also monitor the languages most requested through our interpretive services line for Louisiana members (e.g., number of callers and languages requested) to assess additional needs. Examples of our Plan Benefits Overview brochures in Spanish and Vietnamese have been provided in Attachments T.1-1 and T.1-2. We communicate the availability of materials in additional languages and our free translation services through welcome or member services calls and the *Member Handbook*.

Educational Materials – Proposed Content

The member onboarding and the educational materials we provide help new members get up to speed quickly so they can start using their new health services right away. Based on member research, we know that new members' primary needs are to:

- Make an appointment with the doctor they choose
- Understand their benefits
- Know how to get started and what comes next

Our onboarding process takes these concerns into account with messaging that reassures the member and gives guidance to get started. At the same time, we consistently prompt members through welcome calls, new member orientations and written communications, to take three important actions:

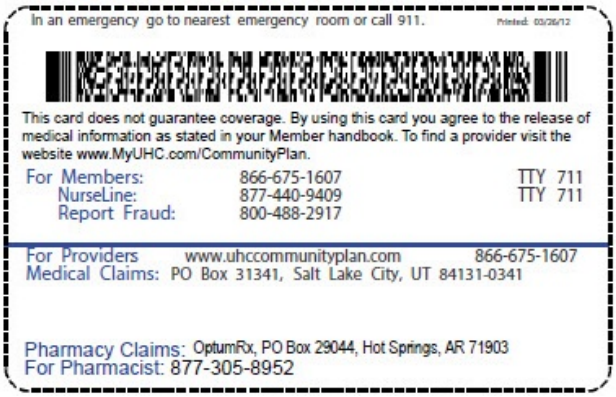
- Confirm their PCP and make their first PCP appointment
- Complete their HRA
- Get to know their health plan and available benefits

Onboarding touch points include:

Days 0-10

- ***ID Cards:*** Within 10 business days of receiving member enrollment data from DHH or the enrollment broker file, the member ID card is mailed to new members. The ID card includes the member's name and date of birth; the member's ID number; our name and address; instructions for emergencies; our member services hotline number and other telephone numbers for filing grievances, contacting provider services, obtaining prior authorization and reporting Medicaid fraud.

  To help our members get started immediately, we include each member's benefits start date in large bold print on the ID card carrier. We also include a brief insert with the ID card that offers a welcome message, and encourages members to make an appointment with their PCP and take their HRA. The insert also lets members know they will receive a welcome mailing within the next seven to 10 days and offers them immediate access to the online member portal. Replacement ID cards can be generated by the member via the member portal (*myuhc.com*), or by calling member services.

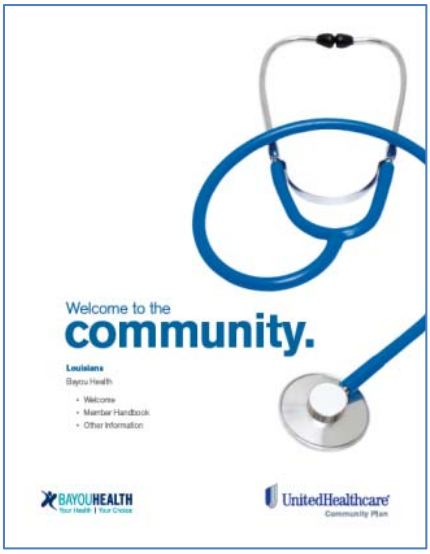


Days 7 - 10

- ***Welcome Mailing/Member Handbooks/Provider Directories:*** We will welcome members with a letter and brochure. The welcome letter and brochure are sent to members within 10 calendar days of receiving member enrollment information via the eligibility files. The welcome brochure highlights the benefits of the online member portal and provides the following information:
  - How to access the most up-to-date provider listings via an interactive Find-a Doctor search tool
  - How to view, download and print the most up-to-date *Member Handbook* in a PDF format

  Members can also request to have a printed *Member Handbook* or provider directory mailed to them by contacting member services.

  The downloadable *Member Handbook* is designed to be easy to read, simple to navigate and is organized according to member preferences. We recently added a Health Plan Highlights section at the front of the handbook that gives members the essential



information they need to get started in a brief summary format.

Days 10-60

- ***Welcome calls:*** Our MSRs call new members to welcome them to the plan. More importantly, this call is used to help members confirm or change their PCP, and complete their HRA. The MSRs also address any concerns the member has and provide additional educational information. The MSRs can talk to new members about their benefits and provide information about the plan, the availability of materials in different languages and our interpretation services, and share preventive health care knowledge.
- ***Clinical Outreach:*** When HRA results indicate a need, our clinical team will follow up the welcome call with another call to members to address potential health needs.

To ensure our members are knowledgeable and have the resources they need to make informed decisions, we provide new member orientation sessions where we share important information and answer member questions.

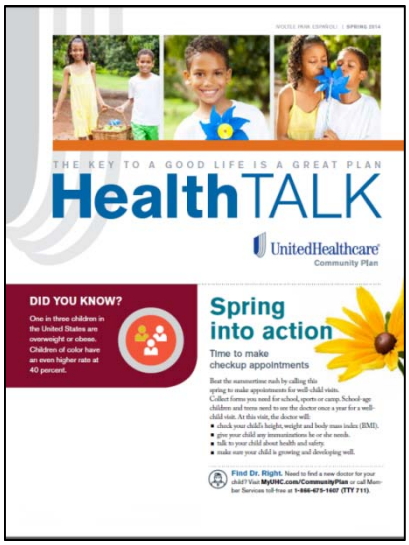
During the initial launch of our Bayou Health CCN-S program in 2012, our outreach team conducted over 20 new member orientation sessions, reaching approximately 430 members across Louisiana.

Ongoing Engagement

- ***Orientation sessions:*** Multiple new member orientation sessions are conducted to assist our members with information on benefits and provide answers to commonly asked questions.

After providing initial engagement materials to our members, we continue to reach out and provide educational materials and other opportunities for learning. The following list provides additional ways we assist our Louisiana members and the public in learning about health and wellness:

- ***Disease Management mailings:*** Disease management mailings are targeted brochures sent to newly identified members diagnosed with chronic conditions and special health care needs such as asthma, diabetes and congestive heart failure, with telephonic follow up by an RN to perform an additional assessment and provide further disease management support. These mailings contain educational information to assist members with managing their disease.
- ***Newsletter:*** *HealthTalk* is our quarterly member newsletter with relevant health education topics, including articles on behavioral health (e.g., attention deficit hyperactivity disorder, suicide prevention) and physical health (e.g., asthma, diabetes, pregnancy, heart health, women's health). *HealthTalk* is available in English and Spanish. We have provided an example of *HealthTalk* in Attachment T.1-3.
- ***Public website:*** We provide a public website,



uhccommunityplan.com, which makes program information such as enrollment, benefits, eligibility, finding a provider, important links to health information, etc. available to the public. This website provides members with the ability to choose English, Spanish or change the language to Vietnamese.

- ***Member Portal:*** We maintain a secure member portal available only to members through the website, *myuhc.com*, to provide information such as telephone contact information, the *Member Handbook*, a searchable list of providers, health care services history, benefits and coverage information, member rights and responsibilities, information on how to file grievances and appeals, etc.
- ***liveandworkwell.com website:*** This website is accessed through a link on our member portal, *myuhc.com*, and includes mental health and well-being information, articles on health conditions, addictions and coping. It also enables members to take self-assessments on a variety of topics, read articles about managing their health and locate community resources.
- ***Educational brochures:*** Educational brochures, designed to teach readers about preventive care and other topics, are disseminated at community events, schools and provider offices. Some examples include:
  - *About Child Checkups and Immunizations*
  - *Deciding when it's an emergency*
  - *Check-ups are Important*
  - *Keep Your Health in Check: Healthy Checkups for Adults*
  - *Be Wise…Immunize*
  - *Managing your Weight*
  - *Tips on Talking with your Doctor*

  We have provided an example of our ER diversion flyer, *Deciding when it's an emergency*, in Attachment T.1-4.

- ***Text4Baby:*** We provide the *Text4Baby* service to connect with expectant mothers and new moms. Through this service, we send out educational text messages with information on pregnancy and child care.
- ***Baby Blocks:*** The *Baby Blocks* program is an interactive website application that reminds and rewards members for attending appointments during pregnancy and into the first 15 months of their baby's life. An example of a *Baby Blocks* brochure has been provided in Attachment T.1-5.
- ***Twitter:*** We deliver health and wellness information related to pregnancy, child birth and general health information applicable to pregnant women through Twitter (*@UHCPregnantCare*). A Spanish version with the same content is available through *@UHCEmbarazada*.
- ***Incentive Programs:*** We call members who have gaps in care and provide education on the importance of being compliant with their recommended screenings. Those members who

complete their specified screenings are rewarded with various incentives including gift cards.

- ***Health4Me:*** The free *Health4Me* mobile application enables mobile users to review health benefits, access claims information, locate in-network providers and contact information, etc.
- ***Smart Patient:*** We provide mobile users with the free *Smart Patient* application. This allows mobile device users to track important numbers such as blood pressure, record appointments, record doctors' orders, view educational videos, etc.
- ***OptumizeMe:*** The free *OptumizeMe* mobile application allows users to set health and fitness goals, challenge other users to set their own goals and post the results on Facebook.
- ***DocGPS:*** We provide mobile users with the free *DocGPS* mobile application. This enables mobile device users to search our provider network and obtain travel directions to a provider's location. The application provides users with the ability to call a provider by tapping on the search result.
- ***KidsHealth®:*** Our online KidsHealth program includes health and wellness resources to encourage healthy behaviors among children, young adults and their parents. A vast amount of content is provided, including assistance for high-risk members with managing conditions such as diabetes, asthma and stress. Videos, written and spoken articles are provided through a link on our website, *myuhc.com*, and can be accessed through a computer, tablet or smartphone.

Marketing Materials – Proposed Content

We provide the following marketing materials in Louisiana:

- ***Marketing publications:*** Additional examples of printed marketing/educational publications we provide to the public include informational diabetes flyers and flu/pneumonia vaccination reminders. We have provided samples of our *Healthy foods for healthy teeth* brochure, informational asthma and maternity flyers in Attachments T.1-6, T.1-7 and T.1-8.
- ***Public service publications:*** We release informational public service publications related to well-being, preventive care and health. Examples include our hurricane preparedness flyer and print media related to obesity in Louisiana. Samples of both are provided in Attachments T.1-9 and T.1-10.
- ***Advertising:*** Our marketing and outreach plan also includes print advertising. We have provided an example of one of our print ads in Attachment T.1-11.

Innovative Member Education Engagement through Outreach Programs

As a State's Bayou Health CCN-S provider since 2012, we successfully developed numerous innovative ways to reach Bayou Health members through specialized outreach programs enhanced by strong partnerships with community organizations in Louisiana and through our commitment to leveraging technology. Our goal is to preserve and enhance our level of

dedication to existing member education programs and introduce new strategies as we continue to provide Bayou Health members with the health education and wellness programs, materials and resources they need to take charge of their health.

Innovative outreach programs we have executed in Louisiana include our 4-H partnership, Heart Smart Sisters, Autism Advisory Council of Louisiana, Sesame Street *Food for Thought*, Boys and Girls Club memberships, our JOIN for ME initiative and other programs as illustrated below.

4-H Programs

The National 4-H Council and UnitedHealthcare Community & State partnered with 10 State Cooperative Extension 4-H programs, including Louisiana, in 2012 to engage families through the Eat 4 Health program. Grants of $30,000 each were awarded to 4-H programs. We reached 7,472 youth and families by Louisiana 4-H through summer camps, the Louisiana State Fair, and other statewide events and activities. The Eat 4 Health program also supports the school garden initiative in West Feliciana Parish, Lafayette, Caddo Parish and Red River Parish. Through school gardening, children can learn science, mathematics, English, environmental studies, health, family and consumer sciences and art. School gardens provide teachers in Louisiana with an excellent opportunity to enrich the educational experience and lives of children. The 2013 Eat 4 Health programs and events held in Louisiana included:

2013 Eat 4 Health Programs and Events in Louisiana		
Program/Event	**Location**	**Approximate Youth and Families Reached**
4-H University	Baton Rouge	1,415
4-H Day with Tigers	Baton Rouge	305
AgMagic @ Louisiana State Fair School Enrichment	Shreveport	1,000
School Garden Training	Lafayette	26
Jr. Leadership Conference (Teen Training)	Pollack	33
Jr. Leadership Conference (all attendees)	Pollack	333
4-H CHEF Club	Hahnville	31
Teen Training	New Orleans	570
Healthy Community Fall Festival & Family Nutrition Night	West Carroll	272
School Gardens	West Feliciana	112
Ad Adventures	Monroe & Delhi	343
Ag Alley	Monroe & Delhi	1,793
Area Cookery Contests	6 Statewide	90
Ag Magic on the River/Ag Wonders	New Orleans	570
School Garden	Lafayette	413
Garden & Nutrition Project	Caddo Parish	146
Community Park Revitalization	Coushatta	20
TOTAL		**7,472**

Additionally, we engaged over 20,000 Louisiana youth and families through the Brush 'n Touch exhibit on display at AgMagic at the 2013 Louisiana State Fair in Shreveport. This exhibit provided good dental habits and tips for healthy teeth.

Heart Smart Sisters™

Figure 44. Heart Smart Sisters Southern University School of Nursing students help with health screening

Heart Smart Sisters is a signature cardiovascular risk screening and intervention program that is designed to empower women to make positive changes in their lives and reduce their relative risk of developing heart disease. Through Heart Smart Sisters, we partner with organizations, businesses, churches and civic groups that share a common goal to advocate for women and become knowledgeable about heart disease prevention and the associated risk factors. The goal is to affect behavioral change through information, education and linkages to physicians and a medical home.

Our Heart Smart Sisters Community Lunch and Learn events exemplify the mission of UnitedHealthcare, which is to help people live healthier lives. By partnering with the Exxon Mobil YMCA, we provide important health and wellness information to an underserved population and position ourselves as contributors to preventive health care. As of March 2014, 13 events have been held, reaching more than 400 Louisiana residents. Additional activities have included:

- Hundreds of hand-held fans distributed to churches lacking air conditioning
- Alpha Kappa Alpha (AKA) Pink Goes Red: Collaboration with five Baton Rouge area AKA Chapters, reaching approximately 300 women, to encourage heart health
- Education sessions featured at dozens of community and faith-based organizations
- Southern University's School of Nursing students volunteer regularly to assist with health screenings for Heart Smart Sisters in East Baton Rouge Parish

Autism Advisory Council of Louisiana

To discuss the impact of autism on families and caregivers in Louisiana, we convened a group of medical professionals, community resources and parents of children with autism in June 2014. This group was established to build partnerships with autism health providers, advocacy groups, state and support organizations. The meeting progressed into the formation of the Autism Advisory Council of Louisiana to raise awareness about the importance of screening and diagnosis, and to improve access to quality, comprehensive and coordinated community-based health care and related services. Additional meetings are scheduled in 2014 to continue organization and partnership growth efforts.

Sesame Street *Food for Thought*

We partnered with Sesame Street and the Merck Company Foundation on the *Food for Thought* program. *Food for Thought* is a bilingual (English-Spanish) multimedia outreach initiative that helps families with children to cope with limited access to affordable and nutritious food. Independent research indicates that *Sesame Street's Food for Thought: Eating Well on a Budget* initiative is helping families increase their knowledge of nutrition and change their eating behaviors. More than 3,500 *Food for Thought: Eating Well on a Budget* kits have been distributed in Louisiana to Head Start Centers, preschools and elementary schools in addition to community and faith-based organizations that serve young children and their parents.

Figure 45. Sesame Street Food for Thought program presented at the St. James Parish Head Start Community Action event.

Boys and Girls Club memberships

We partnered with the Louisiana Alliance of Boys and Girls Clubs and are the only Bayou Health plan to cover the cost of annual membership and broaden access to programs for all children enrolled in our plan. We have donated over $160,000 to the Louisiana Alliance of Boys and Girls Clubs over the past three years. The Louisiana Alliance includes nine Boys and Girls Clubs organizations comprising 40 club sites across the state that serve more than 32,000 children each year. In 2013, 114 UnitedHealthcare members participated in Boys and Girls summer programs.

JOIN for ME

We are proud to partner with the Boys & Girls Club/NFL Youth Education Town in New Orleans to offer JOIN for ME, a community-based childhood obesity lifestyle-intervention program, for families enrolled in UnitedHealthcare. This evidence-based program, which engages the entire family, has demonstrated promise to become a national model to meet the critical need for effective, accessible and affordable treatment for childhood obesity.

- 8,043 engaged via call campaign, physician referrals
- 139 qualified based upon body mass index percentile
- 37 enrolled/scheduled into class (October-December 2012: 14 and January 2013: 23)

In October 2012, UnitedHealthcare and the Louisiana Alliance of Boys & Girls Clubs hosted a community forum to discuss the issue of childhood obesity and to officially announce the launch of the JOIN for ME program.

Stand United…Helping Jaguars Live Healthier Lives

A unique collaboration with Southern University in Baton Rouge provided a series of educational events to help hundreds of Southern University alumni take better control of their health. A kick-off tailgate event featured the following activities that were provided collaboratively with various university and community organizations:

- Safe tailgating tips and information provided by Southern University AgCenter
- Health screenings provided by Southern University School of Nursing
- Health advice and support provided by Walgreens
- UnitedHealthcare Heart Smart Sisters introduction
- Healthy tailgate snacks

Broadmoor High School Health Fair

Broadmoor High School students were given an opportunity to begin 2014 with a healthy start. Along with East Baton Rouge School Base Clinic, we hosted a health fair event in the school gymnasium. Participants included Our Lady of the Lake College, Pennington Biomedical Research, the UnitedHealthcare marketing and quality team with Dr. Health E. Hound[SM] and East Baton Rouge school administrators. Teens were encouraged to go to each health fair exhibit using a passport to receive stickers proving they interacted with each sponsor. Our mission was to provide teens with preventive health care information, encourage healthy eating habits, promote active lifestyles and provide education on careers in the health care industry.

Family Education Opportunity

In June 2013, we participated in the Toles & Arbuckle Family Reunion in the Baton Rouge area, partnering with Pennington Biomedical Research Center to provide information on the prevention and management of diabetes to this large family gathering of 180. The presentation also provided information about the Research Centers ARTIIS Student targeting African-American males who are pre-diabetic or have a family history of diabetes.

Innovative Member Education Engagement through Technology

Other innovative ways we deliver member education is through the use of technology and special programs. We provide members with creative Web-based platforms, educational text programs and useful smartphone applications designed to reach members at work, home or on the go.

Web-Based Member Education

Members can use our member portal, *myuhc.com*, to learn about their benefits, get information on how to stay healthy and find easy-to-understand medical information. Members can also locate providers, print *Member Handbooks*, learn how to contact us and find ways to obtain materials and assistance in other languages.

Our *liveandworkwell.com* website provides our members with the ability to read and learn about topics related to mental illness, chronic medical conditions, work/life balance and updated health news items. This website, accessed through a link on *myuhc.com*, also enables members to take self-assessments on a variety of topics, locate community resources and read about various health and mental health conditions.

Our online *KidsHealth* program provides a vast library of videos, written and spoken articles for children, teens and their parents to help with managing conditions such as asthma, diabetes and stress. Articles are also available about nutrition and fitness, pregnancy and newborns, and caring for children with special needs. This site is designed to engage parents by providing advice from

a trusted source, children through the ability to play games and take quizzes, and teens by providing access to information and personal stories. Resources on KidsHealth are available in English or Spanish.

In addition to our websites, we provide innovative outreach to expectant mothers through Twitter (*@UHCPregnantCare*) by messaging pregnancy, child birth and other health information. To reach Spanish-speaking mothers-to-be, we have also launched our Spanish version, *@UHCEmbarazada*.

Online tools are used to reach members in our *Baby Blocks* program to remind expectant mothers of scheduled doctors' appointments.

Educational Text

Text4Baby is a program where we connect with expectant and new mothers by sending educational text messages that provide information on pregnancy and child care.

Mobile Applications

We also educate members through mobile technology and employ several free mobile applications to provide information for members and the public, such as:

- ***Health4Me:*** Our *Health4Me* mobile application provides our members with a convenient way to access claims information, locate in-network providers, review their health benefits and more. Users can simply download the application to their smartphone and log on, using their *myuhc.com* log in to sign in to their account.

- ***Smart Patient:*** For members coping with a chronic illness or having other reasons to track detailed medical information, our *Smart Patient* mobile application is an extremely valuable resource, allowing users to access important medical information at their fingertips.

  Smart Patient allows users to track essential numbers, such as blood pressure, blood sugar, cholesterol and more. Smart Patient also enables users to manage diagnostic tests, prescriptions, diagnoses, hospital discharges, pre-surgery and organize checklists for doctor's visits. Doctor's orders can be voice-recorded or entered by text. Users can also log upcoming doctor appointments and view educational videos.

- ***OptumizeMe:*** Our fitness mobile application, *OptumizeMe*, enables users to take charge of their own health and wellness by setting goals and challenging themselves. Users are also able to challenge others in their quest for better health and post their goals and challenges on Facebook.
- ***DocGPS:*** Our provider search application, *DocGPS*, allows users to locate the nearest in-network facilities and health care providers. This can be a very helpful tool for users, no matter where they are located. In addition to the "search" feature, this application provides detailed directions and contact information so users can call and schedule an appointment directly from their smartphone.

Providing Equitable Marketing throughout the State

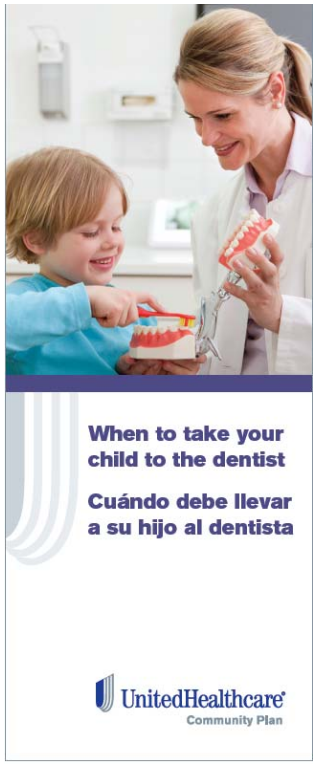
We will continue reaching out to our entire Bayou Health program service area to provide equitable marketing and outreach throughout the state of Louisiana. Our marketing strategies support smaller marketing areas and enable us to reach residents in rural areas. We provide the ability for members with no access to mobile technology or the Internet to obtain informational resources, by mailing materials to them or following through on a telephone request.

Member materials are customized to meet the members' needs with regard to demographics and language. We will continue to develop our outreach strategies based on the unique cultural needs of each community. In this endeavor, we will leverage our existing outreach programs to develop new initiatives to reach potential members.

We also provide community outreach specialists in all areas of the state, where they will continue to develop strong partnerships with community organizations in Louisiana. Our community outreach specialists are able to extend the reach of health care and preventive education into Louisiana communities by providing new and ongoing opportunities for underserved populations that might otherwise be overlooked. Our goal is to provide all segments of the Bayou Health population with the resources and general information they need to take charge of their health.

Member Materials for Carved Out and Behavioral Health Services

We understand the importance of assisting members in need of carved-out services and identify members that are already receiving, or may be in need of, these services through our initial welcome call and HRA. We provide member education and marketing materials to all members in how and where to obtain carved out services. Our *Member Handbook* and member website, *myuhc.com*, provide information about the availability of these services and how to access them.



We provide educational brochures to assist with service coordination of carved out dental services in English and Spanish. Some examples of the materials we provide include the following:

- *When to take your child to the dentist*
- *Healthy Foods for Healthy Teeth*
- *Taking Care of your Baby's Teeth*
- Children's *Healthy Habits Brushing Chart*
- Mobile dental educational programs at schools

To assist with coordination of carved-out behavioral health services, our MSRs are trained to recognize issues that might require behavioral health support and provide assistance to members to obtain the help they need.

As deemed necessary, care coordinators, case managers and PCPs can refer members to the appropriate carved-out health care specialist. We provide training for network providers and case managers on identifying and screening for behavioral health conditions, statewide management organization (SMO) referral procedures and more. We also provide educational materials for

network providers on behavioral health resources, such as methods to deliver psychosocial interventions, engaging members in active participation of their own care and training on our *liveandworkwell.com* behavioral health resource website. We have provided an example of our *Signs of Depression* brochure in Attachment T.1-12.

We will provide our behavioral health support website, *liveandworkwell.com*, under the new contract. This site is accessed through a link on our member portal, *myuhc.com* and includes mental health and well-being information, articles on health conditions, addictions and coping. It also enables members to read articles about managing their health, take self-assessments on a variety of topics and locate community resources.

Mental health and substance use topics are a focus on *liveandworkwell.com* and members can find articles on a variety of topics and download apps such as our Whole Health Tracker, Wellness Recovery Action Plan (WRAP). WRAP enables members to identify mental health triggers, create a wellness toolbox, learn how to cope with symptoms and create a plan if symptoms escalate.

The *liveandworkwell.com* website can also provide a referral link and instructions for members to direct them to specialized behavioral health services through the Louisiana Behavioral Health Program (LBHP). With the appropriate permissions, we will include a link to the SMO's website (*magellanoflouisiana.com*) as well as publicize the Magellan Louisiana Warmline.

As an additional resource, our online KidsHealth program can be used by children, teens and parents to access information and articles about mental health including depression, anxiety, phobias and more. In addition to articles, quizzes and personal stories, KidsHealth provides links to helpful resources, such as the National Mental Health Association (NMHA).

Member Materials Supporting EPSDT Compliance

We are committed to providing our members with preventive health education and continued improvement of EPSDT compliance. For our new members, we conduct welcome calls which include HRAs, allowing us to locate any gaps in the member's care where we can help by providing the member with information, scheduling appointments and arranging transportation.

In addition to outgoing welcome calls, MSRs can check the system for gaps in care when a member calls our member services hotline. The MSR can use the call to educate the member and help to close the gaps by setting up appointments. Our Automated Care Transitions program is another initiative used for coordinating member appointments. Member engagement features are employed through this program, including appointment confirmations and reminders.

We also mail and provide EPSDT-specific educational materials to members. Brochures are disseminated at community events, schools and provider offices. An example of our baby's 9-month checkup reminder brochure is provided in Attachment T.1-13. Other examples include:

- *Check-ups are Important*
- *Be wise…Immunize*
- *Keep Your Health in Check: Healthy Checkups for Adults*
- *Managing your Weight*
- *Tips on Talking with your Doctor*

We use our website, *myuhc.com*, and member newsletter, *HealthTalk*, to provide member education on EPSDT services. *Baby Blocks* is used to remind expectant mothers to attend their prenatal, postpartum and well-baby appointments.

Our *Member Handbook* also provides information about available EPSDT services, who is eligible and how to obtain assistance with appointments and transportation. We have provided an example of our *Member Handbook* in Attachment T.1-14.

Another way we are able to support EPSDT compliance is through the use of health screening events. We engage with local organizations and community leaders to host and sponsor preventive screening events and health fairs where we can provide education and literature on annual checkups and other health-related issues. For example, we co-hosted a health fair with East Baton Rouge School Base Clinic in early 2014 in the Broadmoor High School gymnasium, where we provided teens with preventive health care information and encouraged healthy eating habits and an active lifestyle.

Member incentives provide members with rewards for healthy actions. We help to close gaps in care by contacting non-compliant members and providing education on the importance of being compliant with their recommended screenings. Members who complete their screenings are rewarded in various ways for complying with specific behaviors within each stage of the health care continuum, such as attending preventive health care appointments.

Member Materials Supporting Emergency Room Utilization

Our *Member Handbook* provides information to assist members with determining if they need emergency care. We also distribute an ER diversion flyer and provide education about this topic on our member website. Our MSRs make outreach calls to members who use ER services more than twice in a 12 month period to educate them about other ways to handle illnesses that do not require the ER.

Member Materials Supporting Sexually Transmitted Infection Education

Our targeted outreach for sexually transmitted infection (STI) education includes collaboration with school-based health clinics (SBHCs) by engaging with Health Centers in Schools (HCS), the organization that supports SBHCs in East Baton Rouge Parish. Health clinics held in local schools and communities provide information on STI education and screening and we provide educational brochures to be distributed in medical offices and health fairs. Copies of our brochures, *Sexual Health-Important information to protect you and your partner* and Sexual Health and Teens, have been provided in Attachments T.1-15 and T.1-16. We also provide STI education through our KidsHealth online tool, which contains numerous online articles for teenagers about STIs. Teens and their parents can view or listen to these articles.

Also, STI information can be found on the *liveandworkwell.com* website. This website will be accessed through a link on our member portal, *myuhc.com*.

Member Materials Encourage Prenatal Services and Prematurity Prevention

We believe access to education is the crucial element required to change pregnancy and child care health outcomes in our communities. We provide expectant mothers with critical information related to prenatal care, nutrition, prematurity prevention and parenting through our innovative programs and community outreach.

- ***Healthy First Steps:*** Our Healthy First Steps program is a personalized maternity wellness program that provides members with additional support and education throughout their pregnancy. We work closely with expectant mothers to identify potentially high-risk pregnancies and refer them to high-risk case management.
- ***Baby Blocks:*** Online tools are used with our *Baby Blocks* program to remind and reward members for attending appointments during pregnancy and into the first 15 months of their baby's life.
- ***Healthy Baby Showers:*** UnitedHealthcare has been the sole Bayou Health plan sponsor for the March of Dimes Community Healthy Baby Shower initiative. Through this effort, we reach pregnant women, new moms and their support systems to provide them with education and awareness about prenatal and postpartum care.
- ***Community Brainstorming Session on Teen Pregnancy:*** On June 14, 2014, we invited state, community and faith-based organizations to a brainstorming session to discuss issues and ideas about teen pregnancy in Northeastern Louisiana and ways to improve birth outcomes in this part of the state. This discussion is an ongoing initiative with a planned follow-up to take place in late September 2014 with young women who are most at risk for preterm births and challenges they face.
- ***Educational Initiatives:*** We provide outreach to teenagers in schools and health fairs to educate them about pregnancy prevention and premature births. We provide educational brochures about pre-pregnancy and pregnancy health. We have provided an example of our brochure, *10 things to do before getting pregnant*, in Attachment T.1-17.
- ***Text4Baby:*** Through this program, expectant mothers can receive informative and educational texts about pregnancy and child care.
- ***Outreach calls – HRAs:*** We conduct welcome calls which include HRAs. These calls can also be used to provide information to expectant mothers on the necessity of prenatal care and setting up appointments.
- ***Appointment reminder technology:*** Member engagement features are employed by our Automated Care Transitions program, including appointment reminders and confirmations.

Healthy Baby Showers

"The partnership with UnitedHealthcare enabled us to reach out into the community to provide educational materials and make sure the expectant mothers received critical information to empower them to have a healthy pregnancy. We are very happy with the response we received from the participants about the information provided to them during the showers. We look forward to our continued partnership with UnitedHealthcare and exploring ways to expand the partnership."

--Frankie Robertson, March of Dimes, Louisiana Chapter on our Healthy Baby Showers partnership

Engaging Members through Technology

We understand the importance of providing our members with the ability to access information at their fingertips. We leverage technology to reach our members through mobile technology, social media and websites, as demonstrated below:

Mobile Technology and Social Media

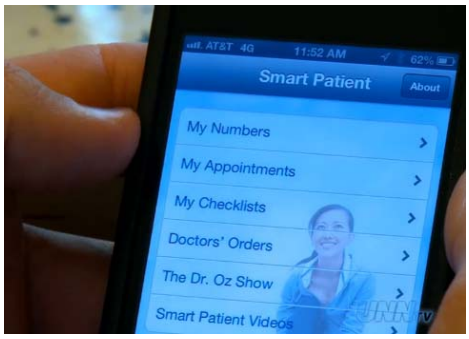
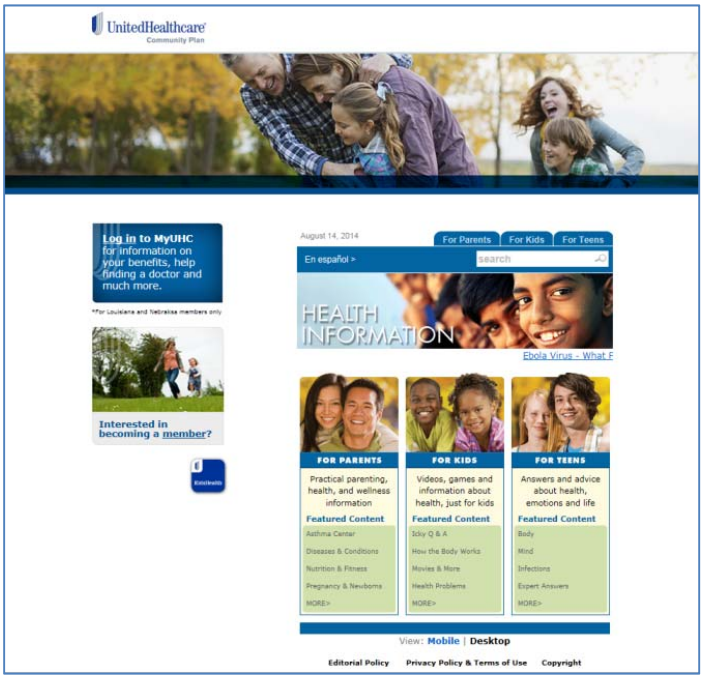


Figure 46 Smart Patient Mobile Application helps users manage their health care

- ***Smart Patient:*** The Smart Patient mobile application enables users to:
  - Track blood pressure, blood sugar, body mass index, total cholesterol and waist measurement
  - Record appointments
  - Manage checklists for doctor visits, diagnostic tests, diagnoses, prescriptions, pre-surgery and hospital discharges
  - Record or type notes related to doctors' orders
  - View educational videos
- ***OptumizeMe:*** Users of the OptumizeMe mobile application can track their progress toward health and fitness goals, post the results on Facebook and challenge other users to create goals.
- ***Text4Baby:*** Pregnant women and new moms can subscribe to this free service which provides educational text messages on pregnancy and well-child care.
- ***Health4Me:*** Our members who are mobile users can log in to their account to locate in-network providers, review health benefits, access claims information and more when using the free *Health4Me* mobile application.
- ***DocGPS:*** We provide a mobile application allowing users with mobile devices to search our provider network and obtain travel directions to a provider's location.
- ***Twitter:*** Through our national Twitter handle, @UHCPregnantCare, we deliver health and wellness information to expectant mothers.



Websites

- ***Consumer website:*** We maintain a consumer website, *uhccommunityplan.com*, which members and potential members can access without registering. It provides information about health plans available by region, specific health plan benefits and a complete listing of network providers.
- ***Member website:*** Our member website, *myuhc.com*, facilitates the dissemination and access of information electronically to our members. Members can also check eligibility and receive information and health reminders specific to their health status. Members can log in using their computer, tablet or smartphone to review their health benefits, access claims information, search for network providers and more.
- ***liveandworkwell.com:*** This website will be accessed from our member portal and will provide members with articles on a variety of wellness topics, allow them to take self-assessments and access mental health and substance use articles.
- ***KidsHealth:*** Our KidsHealth site can be accessed by computer, tablet or smartphone and provides resources to high-risk members for managing their conditions, such as diabetes or asthma. This program also provides wellness and healthy living information and can be used by parents, children and teens.
- ***Online Access to HRA:*** To provide members with a new option to complete their HRA, we are working to provide accessibility through *myuhc.com* and mobile devices. Although Internet access is on the rise, many members are limited to Web connectivity through their smartphone. We expect to increase member engagement by providing our members with Web-based HRA availability.

Partnering with Community Organizations for Education and Outreach

We have developed very strong relationships and ties to the Louisiana communities we serve and are always seeking new opportunities to engage in partnerships where we can provide education and resources to our members and the public. In the section below we have provided detailed information about our community outreach efforts, donations, grants and sponsorships, employee volunteer efforts and support for local community boards in the state.

We recognize and support community needs in Louisiana

Since the implementation of the Bayou Health program, our outreach team has engaged in or hosted more than 1,600 events---reaching an estimated 615,100 Louisiana residents.

We are involved in numerous partnerships with community organizations to provide support and education to our members and the public. Efforts, such as our women's health initiatives, brainstorming sessions on teen pregnancy, community baby showers and more, are provided below:

Women's Health Initiatives

To educate the community on the unique health issues of women, we were instrumental in the development of the Louisiana Center for Health Equity's (LCHE) Women's Health Retreat. Retreats have been held in New Orleans, Baton Rouge and Shreveport. In 2012, UnitedHealthcare was recognized by LCHE as Corporate Partner of the Year for efforts to help eliminate health disparities in the state. Also in 2012, we began an annual tradition of honoring remarkable women making a difference in the greater New Orleans area with Phenomenal Woman of the Year Award. In 2013, we formed the Women's Health Advisory Council, assembling over a dozen thought leaders for an extensive discussion of women's health issues and community needs.

Community Brainstorming Session on Teen Pregnancy

We hosted a meeting with 22 partners June 13, 2014, to share ideas on improving birth outcomes in the state, particularly in Northeast Louisiana where rates of preterm birth are highest. Our initiative to improve birth outcomes in Louisiana is an ongoing endeavor, with a partner survey for additional participant input, a follow-up conversation with young women who are most at risk for preterm birth, and funding for community grants to invest in best practices to improve the health of women and babies in Northeast Louisiana.

Figure 47. Sharing ideas on improving birth outcomes in Louisiana at the Community Brainstorming session on teen pregnancy

Healthy Baby Showers

Our Bayou Health sponsorship of the March of Dimes Community Healthy Baby Shower program has enabled us to reach numerous expectant mothers, new mothers and their support systems to educate and raise awareness of prenatal and postpartum care.

Community Services Connect

Our Community Services Connect™ program helps people in need find housing, food resources, job placement services, clothing, financial assistance, transportation and more. Outreach specialists connect with people in the community to connect them with community services tailored to their needs. Community Services Connect is mobile and can set up where they are needed.

Preventive Health Screening Events

We support and collaborate with a wide array of screening events to promote health and bring awareness to the importance of keeping our members' health in check. Since the implementation of the Bayou Health program, our outreach team has engaged in or hosted more than 150 health screening events and health fairs, reaching approximately 43,000 state residents.

School-Based Events

We team up with schools to offer health and resource fairs as well as other events. Since the implementation of the Bayou Health program, outreach team has been involved in more than 300 events in the state, such as back-to-school supply drives, bullying prevention seminars and summer camps that support health education in schools, reaching more than 50,000 children.

Figure 48. 2014 IronKids Race. Kids in New Orleans kick off the IronKids race with Dr. Health E. Hound

IronKids Youth Race in Louisiana

As a national sponsor of IronKids, we sponsored the first IronKids youth race in New Orleans in 2014. The objective of this event was to inspire and motivate young people to lead active, positive and healthy lifestyles. UnitedHealthcare mascot Dr. Health E. Hound participated in the event, helping the participants and their parents with warm-up exercises and joining the participants at the starting line to officially kick-off the race. We donated 50 complimentary race

admissions to the Boys & Girls Club of Southeast Louisiana. UnitedHealthcare employees were present to cheer on the participants, provide hands-on activities such as games and exercises and distribute educational materials.

Girl UP NOLA

We partnered with Girl UP NOLA, led by New Orleans first lady Cheryl Landrieu, an initiative formed to connect New Orleans girls with positive role models and increase their access to opportunities and resources. An all-day conference hosted 75 girls in September 2013, providing lessons ranging from self-esteem to goal setting to physical fitness. A fun day of health education was provided to 15 girls and their families in August 2013, where participants were introduced to healthy food selection.

Grandparents Raising Grandchildren Support Groups

Grandparents Raising Grandchildren is a support group for grandparents who have become responsible for caring for their grandchildren. We have engaged in 24 events/meetings with Grandparents Raising Grandchildren support groups, presenting Heart Smart Sisters programs to provide education on heart disease.

Family Road of Greater Baton Rouge

Family Road of Greater Baton Rouge is a nonprofit organization providing services for families, such as prenatal clinics, fatherhood classes and counseling programs. We have contributed graphic design and printing of community program/education calendars Family Road of Greater Baton Rouge in addition to providing monthly health education classes.

East Baton Rouge Council on Aging

The East Baton Rouge Council on Aging (EBRCOA) provides various services to approximately 6,000 seniors living in the Baton Rouge area, including daily meals, transportation, senior programs, access to health and social supports and assistance to those in need. UnitedHealthcare and EBRCOA have collaborated to support the Meals on Wheels program, delivering approximately 125,000 meals annually to needy Baton Rouge community members and providing wellness programs and activities for seniors.

Ouachita Parish Council on Aging

The Ouachita Parish includes poor communities and needy seniors; the Ouachita Parish Council on Aging (OPCOA) is challenged in supporting this large community with limited funding and support. Additionally, the OPCOA has significant transportation challenges with little financial support. We partnered with OPCOA to sponsor their Meals on Wheels program serving the seniors of Northeast Louisiana. Our support reaches hundreds of seniors in the community who would normally not receive a hot and nutritious meal delivered to their front door.

Childhood and Family Learning Foundation

The Childhood and Family Learning Foundation (CFLF) represents child advocates, educators and service providers in New Orleans. The CFLF works to address the origin of student achievement gaps by providing comprehensive health assessments for children and, based upon the findings, offer targeted services from health care providers and faculty to help each child thrive physically, thus impacting academic performance. We have partnered with CFLF to create a pilot program to increase access to health care for children and youth and our investment will support creation of a Whole Child program to provide quality health programs and better outcomes for children.

Youth Obesity Understanding for Training and Health

We are excited about working on several new initiatives aimed at reducing childhood obesity and increasing physical activity by supporting two new fitness and youth engagement programs in North and Central Louisiana. These programs include participation by NBA star and Baton Rouge native Glenn 'Big Baby' Davis and Shreveport's own Fit4Life's Robert 'Superman' Blount. These two programs will reach an audience of 30,000 youth and provide exercise opportunities, a focus on fitness, healthy lifestyle tips and positive motivation for area youth.

Community Initiatives

We contributed nearly $200,000 in financial and in kind support for community initiatives in the non-English speaking communities we serve through translated materials and participation in events such as Cinco de Mayo, Vietnamese New Year and the Young Asian Professionals Annual Vietnamese Health Fair, which attracts more than 600 attendees each year.

Educational Initiatives

We have provided support for DHH's initiative to educate the community on changes to Medicaid by participating in 120 town hall and community information meetings as well as conducting our own town halls with providers and community leaders.

Community Donations, Grants and Sponsorships

We recognize and support community needs in Louisiana through various donations, grants and sponsorships. Recent efforts include the following:

Daughters of Charity

Daughters of Charity has a long-standing history of providing community health services in New Orleans. UnitedHealth Foundation recently granted $550,000 to Daughters of Charity to support its clinic in New Orleans East, an area still recovering from the devastation of Hurricane Katrina.

Battling Childhood Obesity with HEROES

The UnitedHealth HEROES wellness initiative was developed by UnitedHealthcare and Youth Service America (YSA) to inspire young people, working with educators and youth leaders, to implement walking, running or hiking programs to decrease childhood obesity. In 2013, several HEROES grants of up to $1,000 each were awarded to several Louisiana schools and community-based nonprofit organizations including Alcohol and Drug Abuse Council, North Louisiana Community Enhancement Corporation, Northwestern State University, Forest Hill Elementary and YMCA of Northeast Louisiana.

Community Computer Donations

We donated over 400 computers in 2013 and 2014 to the following recipients.

- 232-HELP/211 Hotline, Lafayette
- A Silent Life, Inc., New Orleans
- Agape Baptist Church, Baton Rouge
- Better Tomorrows, New Orleans

Community Computer Donations

"The computers have served as a useful tool for members of my community to access job opportunities, learn basic computer skills, search the web and improve inferior reading and writing skills. A large percentage of this community would not otherwise have access to the web or job applications if it weren't for the computer donation made by UnitedHealthcare. We appreciate the donation more than you know."

Candice McMillian- Director, Exodus Place, New Orleans

- Catholic Charities of North Louisiana, Shreveport
- Community School for Apprentice Learning, Baton Rouge
- Ebenezer Baptist Church, Baton Rouge
- Evening Star Baptist Church, New Orleans
- Exodus Place, New Orleans
- Fit for Life Ministries, Shreveport
- Friends of Joe W. Brown Memorial Park, New Orleans
- Gardere Initiative, Baton Rouge
- Glen "Big Baby" Davis Foundation, Baton Rouge
- Goodwill Industries of Acadiana, Lafayette
- Israelite Community Development Corporation, Crowley
- Love Impact, Inc., New Orleans
- Madison Preparatory Academy, Baton Rouge
- PREACH, Baton Rouge
- Progressive Baptist Church After-School Tutorial Program, Lafayette
- Progressive Baptist Church, Lafayette
- Progressive Community Outreach Center, Lafayette
- Sickle Cell Anemia Foundation, Baton Rouge
- St. Marc School of Religion, Ama
- St. Rest Missionary Baptist Church, Shreveport
- Student Learning Center, Baton Rouge
- The Providence House, Shreveport
- True Vine Baptist Church, Westwego
- Vietnamese Initiatives in Economic Training (VIET), New Orleans
- YOUTHanasia Foundation, Inc., Harvey

Figure 49. Louisiana students using computers provided through UnitedHealthcare community donations

Wounded Warriors

We sponsored the Gulf Coast Ride 2 Recovery Tour kick-off event in New Orleans in 2013. Over 200 cyclists, including UnitedHealthcare employees, participated in the event. Ride 2 Recovery supports physical and psychological rehabilitation programs for injured veterans. We annually serve as Ride 2 Recovery's presenting sponsor, providing financial and volunteer support.

American Heart Association – Walking Path

We are working with the American Heart Association to help locate walking paths throughout Southeast Louisiana. The national goal is to create 150 walking paths across the country over a 3-year period. UnitedHealthcare has put approximately $2 million into this national campaign to make walking paths a reality. These paths are meant to provide safe and accessible fitness resources to the community. Listed below are three walking paths currently in the New Orleans area supported by UnitedHealthcare:

- Duncan Plaza
- Palmer Park
- Lafayette Square

Additionally, local resident, Glen Golemi, a senior executive managing our commercial business in the Gulf States Region, currently serves as Chairman of the American Heart Association's Southeast board of directors. In March 2014, Mr. Golemi was awarded a 2014 Health Care Hero by New Orleans City Business. Mr. Golemi was recognized for his more than 30 years of leadership experience in the health care and health benefits industry.

Employee Volunteer Efforts

Employee Giving and Volunteerism

Numerous organizations in Louisiana, such as the American Heart Association, Second Harvest Food Bank and March of Dimes, have been supported through our annual Employee Giving campaign. Employee contributions from 2011 through 2013 have totaled $305,095.

In addition, our employees have donated their time, contributing over 5,300 volunteer hours from 2011 through 2013 to Louisiana community organizations and causes.

Our employees are engaged in Louisiana communities and frequently support volunteer efforts, through monetary donations and volunteer hours for local organizations. Employee volunteer efforts, such as support for the Holy Ghost Catholic School, donation events and community improvement, are detailed below:

Holy Ghost Catholic School

Our employees embarked in an effort to support Holy Ghost Catholic School, a nearly century-old kindergarten through eighth grade school in New Orleans, in 2012. Volunteers have worked on building repairs and landscaping, book donations and bake sales. They have also held a school supplies drive and made over $1,300 in individual contributions.

Donation Events

Our employees contributed toward the following events in 2013:

- Hosted a drive to collect clothing, household and cleaning items for Catholic Charities and residents of LaPlace affected by Hurricane Isaac
- Participated in Samaritan's Purse Christmas event to fill shoe boxes with small gifts for children in Third World countries
- Partnered with The Salvation Army in their "Adopt-A-Family" program to adopt two families, including five children, and provide them with gifts at Christmas

Sankofa Community Development

Our employees volunteered with Sankofa New Orleans to assist with their efforts in rebuilding and repurposing the St. Claude Court Community Garden to improve local access to healthy foods.

Figure 50. Sankofa Community Development Volunteers work with Sankofa New Orleans on the St. Claude Court Community Garden

Support for Community Boards

Our leaders strengthen the community by providing support to the following community boards:

Ann Kay Logarbo, M.D., Chief Medical Officer

- Basket of Hope - Louisiana Chapter: board of directors
- N. Cefalu Company: board of directors
- Mother-Daughter/Father-Son Program, Archdiocese of New Orleans: Speaker
- Helping Hands Medical Mission: Volunteer
- Seelos Center of New Orleans: Blessor

Karl Lirette, Chief Operating Officer

- Ormond Civic Association: Vice President (homeowner's association)

Brad Grundmeyer, Member Services Manager

- Jefferson Chamber of Commerce: Served in 2011 as Chairman.
- American Red Cross of Southeast Louisiana: Elected to board of directors in 2012
- St. Charles Borromeo Pastoral Council: Council member and communications director
- Volunteer New Orleans: Founder and organizer
- Louisiana Cares: Founder and organizer

T.2 Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated. How will this information be available to members and the public? (2 points)

We strive to meet the needs of our members and to empower them to participate in their own care and understand the importance of providing Bayou Health members with information that is timely and accurate. At any time, members can get online access to the directory or can request a printed copy of the provider directory – updated weekly -- through the member services center and we will mail a copy of the most current version.

Through our community involvement, provider advocate messaging, our physician demographic verification program and even our strong ties to the Louisiana Primary Care Association, we continue to build inroads and relationships in the provider community to provide members with current and accurate information.

Our fully staffed operational resources intersect with providers at all levels of the contracting relationship – in person, by phone or email – to ensure the collection of accurate provider data that is easily accessible to members both online and in hard copy.

Participating providers are contractually required to notify the plan of any changes to their participation in the plan and provide updates to their contact information. If the plan receives this information through another source such as reports from field representatives or member calls, the plan immediately contacts the provider to validate the accuracy of the information being provided.

Maintaining Current Provider Directory Network Information

We will continue to maintain an online searchable directory and a PDF directory formatted for print production. Both versions are available to members, potential members, network providers and all UnitedHealthcare staff members. Further, we will continue to make available hard copy Provider Directories in State Medicaid Regional Offices, the CCOs' offices, Women Infant and

Children (WIC) offices, upon member request and other areas as directed by DHH. As we have in the past, we will continue to comply with each specification and requirement outlined in Scope of Work 12.14, Provider Directory for Members.

Provider Data

Our network database (NDB) includes a wealth of demographic and practice information for both participating providers and facilities. This information includes, but is not limited to facility names, individual practitioner names, contract effective dates, state Medicaid IDs, tax IDs, national provider identification (NPI) numbers, practice locations, remit address, telephone numbers, fax numbers, email addresses and non-English languages spoken. All required provider directory elements will be extracted from the NDB and published as described below to maintain compliance with specific requirements identified by DHH.

Production Process for Ensuring Accurate and Up-to-Date Provider Directories

We have processes in place to make sure our online and printed provider directory is updated weekly and that the printed directories we maintain on-hand are available and as up to date as possible. Data for all participating providers, including sub-contracted vendor data, is extracted into a defined file layout for both paper and online directory production. The file extraction process is executed daily to make certain the online provider directory data are updated each night. Additionally, the same file extract logic is executed weekly and submitted to our provider directory print vendor, Standard Register, each Friday.

Subsequent to this weekly submission, Standard Register uses the data to produce a new paper directory PDF each week to support all fulfillment orders processed within that week. The printing of our provider directory is executed on demand to make sure each member receives an updated and current paper directory upon request. We also maintain an adequate supply of up-to-date hard copies so paper directories are ready for delivery to State Medicaid Regional Offices, WIC offices and other areas as directed by the Division.

Maintaining Provider Directory Network Information

We recognize the importance of maintaining up-to-date provider data, and we strive to meet the needs of our members and empower them to participate in their own care. As a way of keeping our members informed, we require participating providers to notify us of any changes to their participation in our plan and provide updates to contact information that may affect member access.

We identify provider data changes through a number of mechanisms including provider-initiated changes though our provider call center or submission via the online provider portal and through securing updates from the Council for Affordable Quality HealthCare (CAQH), National Plan & Provider Enumeration System (NPPES) or other industry sources of truth.

During 2014 we launched the Network Verification Initiative in Louisiana in which we compared CAQH provider data with the information in our system. As part of our in-depth review, we identified providers requiring outreach. Using a combination of fax and outbound calls, our initial verification activity in Louisiana was recently completed and resulted in more than 2,000 updated records. Other initiatives include developing a fully integrated feed between us and CAQH, educating providers about the value of maintaining current CAQH information, and establishing CAQH as the universal data source. Our goal is to implement CAQH as the

industry source of truth and to streamline the provider's experience in working with multiple payers.

We routinely confirm provider contact information during each interaction with providers – in person, by phone or email and may also become aware of provider changes through our Provider Relations field representatives team, or through feedback as described below.

- ***Provider Verification Outreach (PVO) Team:*** PVO representatives initiate contact by phone, fax, email or in-person to confirm all required provider directory data elements such as name, location, office hours, telephone numbers, non-English languages spoken by provider or office staff and whether or not the provider is accepting new patients. Contact with Louisiana providers is initiated proactively at least annually and as a result of requests from provider relations, health services or member services related to member or provider inquiries.
- ***Provider Relations Team:*** This field-based team features provider advocates who live and work in Louisiana and routinely call on providers to deliver education and assistance regarding UnitedHealthcare processes, and to maintain positive collaborative relationships. Providers are encouraged to bring any questions or needs, including updates to practice or personnel information, directly to their advocate for prompt handling.
- ***Provider Services Center:*** Providers have the option to call the provider services help line to update any data elements in their profile through our provider phone representatives (PPRs). Our PPRs are also trained to verify provider information as they are working with providers on other questions and concerns.
- ***Network Account Management Team:*** This outward facing team represents another resource for our Louisiana providers to update demographic or practice information. This department handles the contracting process and works directly with providers to establish, maintain and correct provider data elements.
- ***Online Provider Updates:*** Through BayouCloud, our online provider portal, providers have the ability to directly submit updates to their provider contact information.

T.3 Describe how you will fulfill Internet presence and Web site requirements, as well as any social media components. (3 points)

Fulfilling Internet Presence and Website Requirements

Member Website

Our existing UnitedHealthcare member website, *myuhc.com*, complies with the website guidelines in Section 12.10 and includes the following:

- A member-focused section which is interactive and accessible using mobile devices with capability for bidirectional communications (questions and answers)
- The most recent version of the *Member Handbook*

Our Member Portal, *myuhc.com*, is intuitive and provides educational and time-saving features. Our monthly utilization reports demonstrate that this is a valuable resource for our members:

Key Function Areas	Visits
Benefits	381
Eligibility	211
Medical-Your Coverage	155
Search – Physicians	131
Account Balances	89
ID Cards	83

- Telephone contact information to include toll-free member services number and TDD number
- Searchable list of providers
- Link to enrollment broker website and toll free number
- Section for providers, including contact information, claims submittal information, prior authorization instructions and toll free number
- General customer service information
- Information on how to file grievances and appeals

Members can also register on *myuhc.com* and our mobile app, Health4Me, and experience a powerful online tool with features that can help them stay healthy and save time. Our website is designed to meet the unique needs and challenges of our members, including appropriate reading levels, multiple language offerings and culturally appropriate materials.

We continue to enhance website accessibility for disabled individuals as technology standards and industry requirements continue to evolve. For example, a recent *myuhc.com* update included enhancements for accessing all site elements via keyboard, increasing color and text contrast, improving semantic markup, increasing form accessibility and making keyboard navigation more usable.

Additional website functionality we provide includes:

- Online health assessment/personal health profile
- Ability to receive health reminders specific to the member's health status
- Ability to print or request a member ID card
- Coverage status
- Benefits search
- PCP assignment
- Health care services history
- Member survey to record member's experience with the website

Members can also check eligibility and receive information and health reminders specific to their health status. Menus provide options for members ranging from program offerings with member publications in multiple languages to member responsibilities and privacy information. Members may select a provider based upon member program and preference.

Our program website provides helpful plan-specific links to a variety of services and information for members (see screenshot below).

We are continually updating content and improving the member experience on *myuhc.com*. In another effort to increase member engagement, we will provide accessibility of the HRA to members on *myuhc.com*.

Additional Internet Resources

In addition to our member website, we provide access to useful Internet resources for health and well-being, such as *Baby Blocks*, a program which supports and rewards expectant mothers who provide their newborns with a healthy start by attending doctor's visits. Our KidsHealth website is accessible from computers, tablets or smart phones and provides health facts and valuable advice for children, teens and parents. Our *liveandworkwell.com* website, accessible from *myuhc.com*, provides behavioral health information in addition to health conditions, addictions and coping.

Mobile Applications

We offer mobile applications available to our members and the public, such as Smart Patient, a practical tool used by patients to record doctors' orders, track important numbers such as blood pressure, and manage prescriptions and diagnostic tests. This application is particularly helpful to patients who are coping with chronic illnesses and multiple diagnoses. We also provide a fitness application, OptumizeMe, which allows users to set healthy living goals and challenge others to do the same. Our DocGPS application assists members with locating in-network health providers

and facilities. Members can download and log in to our Health4Me application to access claims information, review health benefits and more.

Social Media Components

Expectant mothers can follow us on Twitter, *@UHCPregnantCare*, where our messaging delivers health and wellness information relating to pregnancy, child birth and general health information applicable to pregnant women. Additionally, we launched a Spanish handle in January, *@UHCEmbarazada*, which includes the same content as *@UHCPregnantCare*, but allows our audience the option to choose their preferred language.

T.4 Describe how you will ensure culturally-competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each, including description how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services. (5 points)

Efforts to Promote Health Equity Recognized in LA
The Louisiana Center for Health Equity recognized the UnitedHealthcare for its efforts to eliminate health disparities in the state caused by poverty, lack of access to quality health care and unhealthy environmental conditions with a focus on wellness and community health. This work includes a first-of-its kind series of women's health forums held throughout Louisiana.

We will continue to provide the resources and willingness to work with Bayou Health program members in a way that values their culture, traditions and language. We have a strong presence in the state with members and their families and welcome the opportunity to further our efforts to offer programs and services that reflects an understanding and appreciation for the cultural diversity of members, the community, and local customs and language in compliance with Section 4.6.3. This includes providing member materials that are member-centric, culturally inclusive and accessible to non-English speaking members along with the provision of alternate communication mechanisms in compliance with Section 12.2

To facilitate quality care for all member populations and to attract new members, we provide and foster services to members that are culturally competent and which meet the unique needs of Bayou Health members. Our efforts amount to more than simply language translation services or multicultural member communication. But rather, we have focused our ability to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs. In fact, in the 2013 NCQA Standards and Guidelines for the Accreditation of Health Plans report, **UnitedHealthcare of Louisiana received a score of 100 percent for quality management which includes the cultural competency score.**

Bayou Health Contract Requirements	Points Received	Possible Points	0% 20% 40% 60% 80% 100%
Quality Management*	19.14	19.14	**100**
Members' Rights Responsibilities	8.93	9.01	**98.08**

** Includes cultural competency as NCQA Report QI.4.*

Our efforts to acknowledge and support the impact culturally competent care has on improving health outcomes in the state of Louisiana include:

- ***Analytics:*** Integrating member age, gender, address, race/ethnicity and language data with member clinical data to identify disparities in care that are associated with these member demographics.
- ***Cultural Competence:*** Providing clinical and non-clinical cultural competency training to staff to create awareness of the unique needs of members from various cultures resulting in the delivery of personalized service that enables a connection with the member to meet their needs.
- ***Outreach:*** Customizing member materials and engagement strategies based upon unique cultural needs and identified gaps in care.
- ***Providers:*** We foster culturally competent care by providing Bayou Health members with PCPs that speak with language and know their culture. In 2013, members reported that in the past six months):
  - ***"It was never hard to find a personal doctor who speaks [my] language." (83.59%)***
  - ***"It was never hard to find a personal doctor who knows [my] culture." (80.60%)***
- ***Community Involvement:*** In addition to our active community engagement, we will develop and establish the *LA Bayou Community Health Equity Committee*. This committee will allow for stakeholder involvement in the development, implementation and evaluation of programs, policies and services aimed at improving health equity and eliminating health disparities as a foundational strategy. Through this approach, we will ensure culturally competent services to Bayou Health program members of all cultures, races, ethnic backgrounds, religions and disabilities. Critical pillars to our approach are: Staff Training, Care Management and Community-Based Outreach.

Disparities in Care
Though Louisiana ranks 40th in the United States in incidence of breast cancer, **the State ranks 2nd highest in mortality from the disease.** Likewise, African Americans are more likely to have asthma than their Caucasian counterparts.

Staff Training

We will maintain at least 50 percent local, Louisiana-based staff. Our local staff live and work in the state and are members of the community. They are passionate and committed to helping Bayou Health program members and they live this passionate commitment every day. Our member services representatives are trained and prepared to engage with Bayou Health program members. In compliance with Section 4.6.3, our staff will be trained in the geography, culture and correct pronunciation of cities, towns and surnames. They will also have a broad range of tools to create a safe, helpful, meaningful experience for every member, with a focus on resolving issues quickly and taking ownership of the member's experience.

To provide the best service for our members with communication challenges, we determine the need for changes or additions to verbal and written member tools by collecting data on ethnicity and preferred written and spoken languages for members and conduct analyses of this data to perform a cultural and linguistic assessment. We track the number of incoming calls to the member services center requesting the use of an interpreter via our interpretation services, and the number of requests for materials written in languages other than English or in alternative formats, to ultimately best meet our Bayou Health members' health care needs.

Handling Calls from Members with Limited English Proficiency

Delivering a consistent member experience as part of our "one-stop" service model includes focusing on the quality of the interaction with our members and providing personalized service, including speaking to the member in their first language. Accessible and appropriate linguistic services are the foundation of culturally proficient health care and upon enrollment into our health plans, the member's need for linguistic and translation services is determined and noted in the member's record. We currently employ plan advocates who are fluent in Spanish to assist members in Louisiana, and our interpretation services are always available to provide our members with access to more than 170 languages to meet their communication needs.

Dr. Logarbo Helps Members Live Healthier Lives

Dr. Ann Kay Logarbo, chief medical officer, became aware of a male patient who had gone to the ER 53 times for his asthma. Dr. Logarbo called the hospital and asked to be telephoned the next time he arrived at the ER. One day, she received the call that he was in the ER. Immediately, she made her way to the hospital, met with the patient and got him involved in asthma case management. This is just one example of how we bring clinical expertise and passion to helping people live healthier lives.

Handling Calls from Persons Who Are Hearing Impaired

We use the 711 National Telecommunications Relay Service (TRS) TTY line to facilitate communication with hearing impaired members, and print the telephone contact information on all member mailings and marketing materials. Plan advocates are trained on handling calls from TRS operators who are assisting our hearing impaired members. When the office is closed, the TRS operator can leave a message on the system requesting a call back. Those messages are returned by the next business day using TRS via 711.

Care Management

Creating meaningful partnerships with unique populations to improve health outcomes can be a challenge. We have broad experience developing and designing member-focused care management programs that address the needs of uniquely diverse populations. Recognizing that behaviors can be effectively changed to improved health when they are "endorsed" by trusted sources in one's culture, health education has been delivered across cultures based upon unique characteristics and customs that exist within them.

Improving Health Outcomes in Diverse Population

UnitedHealthcare partnered with **Pennington Biomedical Research Center in Baton Rouge to address the prevalence of diabetes among African-Americans.** It is estimated that between 15 percent and 20 percent of African Americans have diabetes. Diabetes is associated with heart disease, stroke, high blood pressure and other health issues that affect African Americans in high rates. The prevalence of diabetes has increased more in African Americans than any other ethnic group in the past 15 years.

Family reunions, being a well-established custom, provide a highly acceptable vehicle to talk frankly about diabetes. This provided us with the opportunity to engage with the Toles-Arbuckle Family Reunion held in the Baton Rouge area to participate in the Pennington study. The family's participation in the study validated the information presented as valuable and pertinent to all family members. UnitedHealthcare and Pennington provided strategies and support through ARTIIS Study targeting African-American males who are pre-diabetic or have a family history of diabetes. Today, the Pennington study continues to engage the African American community in furthering their research to find solutions related to diabetes.

We also participated in popular celebrations in the Hispanic and Vietnamese communities – **like Cinco de Mayo and Vietnamese New Year festivals** -- that were well attended. We provided translated materials and translators upon request. These events are held within the communities where education about Bayou Health, disease management, and living a healthier lifestyle occurs in familiar and safe environments.

Faith-based organizations in many cultures also provide great access to members who are accustomed to honest and open conversations about their lifestyle, including health. UnitedHealthcare's **Heart Smart Sisters workshops address the prevalence of heart disease among women.** The program has been presented at many church events throughout Louisiana such as health fairs, women's meetings and denominational conferences. Events that target women have been an excellent way to address heart disease, high blood pressure, diabetes, nutrition, and exercise using the Heart Smart Sisters program. Since 2012, Heart Smart Sisters presentations have been featured during Women's Week, an annual event of the Women's Council of Greater Baton Rouge.

Figure 51. Community Brainstorming Session on Teen Pregnancy in Louisiana.

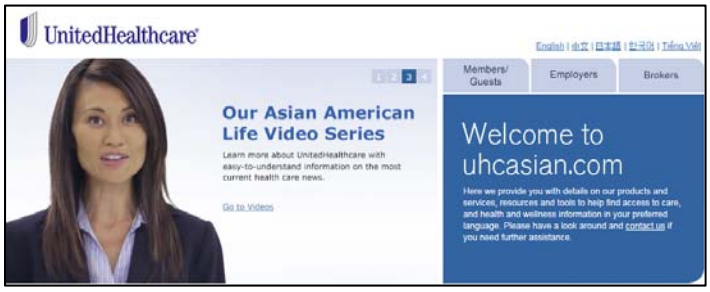
Member Engagement in Healthy Outcomes

Reaching out to members in the most meaningful way possible is critical to member engagement. As such, UnitedHealthcare has the ability to leverage text messaging technology to provide important education related to key topics such as chronic health conditions and children's health. We know that reducing the premature birth rate, preventing unwanted pregnancy, the dangers of closely spaced pregnancies and the importance of prenatal care is of special interest to the state of Louisiana. We have in place several Internet and social media initiatives that engage the member populations based upon their culture, interests, generation or "life cycle" and encourage healthy habits such as:

- ***Text4Baby***: Our text program, which sends out educational text messages to provide expectant mothers with information on child care and pregnancy to send reminder texts regarding PCP selection for newborns.
- ***Twitter@UHCPregnantCare:*** The national Twitter handle @UHCPregnantCare targets our TANF audience who parallels Twitter's demographics. @UHCPregnantCare's messaging delivers health and wellness information relating to pregnancy, child birth and general health information applicable to pregnant women. We launched the first enterprise Spanish handle in January.
- ***@UHCEmbarazada (UHCPregnancy):*** Provides the same content as @UHCPregnantCare, but the Spanish handle gives our audience the option to choose their preferred language. All promotional materials are offered in Spanish as well.
- ***Health4Me:*** The free *Health4Me* mobile application enables mobile users to review health benefits, access claims information, locate in-network providers and contact information.
- We have provided samples of member communications as Attachment T.4.

We have also designed Internet outreach and phone applications that address racial disparities and encourage culturally appropriate health actions.

- ***Generations of Wellness:*** This popular website addresses racial disparities with Web content and videos. It provides culturally relevant health information to help African-American members improve their health outcomes (*uhc.com/generationsofwellness.com*).
- ***UHCAsian.com:*** In the New Orleans area in particular, there is a high concentration of Vietnamese members and their families. Our website, *uhcasian.com*, provides Asian members with information related to cervical cancer screenings--a State performance measure—and offers mailings and outreach to address the high-incidence of cervical cancer among Asian-American women.



Special Health Needs, Special Attention

We are committed to addressing the unique needs of Bayou Health members and to embrace the cultural diversity of the State to promote improved health outcomes.

Supporting Vietnamese Members

We propose a new interactive voice response program that will support the state's Louisiana Vietnamese which are estimated at 25,000 individuals, the majority living in the New Orleans area. For these members, we will build out the capability of our current member services greeting to provide members with an option for Vietnamese language in addition to English or Spanish language options. We will collaborate with DHH on a call script and translate it into Vietnamese for recording by a native speaker.

Sickle Cell Chronic Disease Management

We propose a member outreach campaign to provide resources to help members live with sickle cell disease (SCD), a condition that creates a significant health disparity for African-American and Hispanics. Louisiana has a high incidence of SCD statewide. Sickle cell-related diagnoses are a top five cause of ER visits and inpatient admissions and a trigger for pain management needs.

Our national clinical team has significant experience managing the care of members with SCD, and therefore they understand the unique needs of these members. We have leveraged this team's expertise to develop an SCD program that enhances our person-centered clinical model by offering timely SCD-specific interventions and resources, which are tailored to individual member needs. Our SCD program addresses the challenges unique to each stage of life—from newborn through adulthood—to mitigate disease progression and complications and improve the quality of life for members with SCD. Our SCD expertise includes:

- Associate medical director Dr. Lanetta Jordan, a world-renowned expert in sickle cell disease, helped develop our SCD program. She participated in the development of national SCD evidence-based guidelines sponsored by the National Institutes of Health (NIH).
- Our national clinical team has a combination of Medicaid experience and hands-on experience managing members with SCD.
- Sickle cell disease medical director Dr. Paul Monte is American Board of Internal Medicine-certified and has significant experience managing patients with SCD in a hospital setting. Dr. Monte oversees our national SCD program.
- National SCD expert panel, comprising board-certified experts in treating members with SCD, reviews and updates all clinical components of our program under the oversight of Dr. Monte.

Sickle Cell Outreach program identified Louisiana members with sickle cell disease and provided trained nurses to conduct outreach phone calls. The purpose of the outreach was to provide education and engage the member with a PCP and provider experienced in treating sickle cell disease or a specialist that can work with the member to properly manage their condition. We completed the outreach June 1, 2014. We contacted 366 members and reached and educated 141 members (39%). 50 members received written education and 20 members asked to speak with a case manager and were referred to case management.

Our national clinical quality team is adopting SCD evidence-based guidelines tailored to the needs of Louisiana members, based upon the NIH guidelines (e.g., clinical trials or managing transplants for members with SCD). The team has also developed a pain management process to help SCD members manage their daily pain levels so they are not visiting the emergency room or being admitting to the hospital.

Sickle Cell Health Outreach Efforts

As a result of this customized health outreach campaign, we are taking the following actions that work to eliminate health disparities through a significant effort to provide expert consultation, provider education and member engagement in improved health care outcomes.

- Identifying gaps in our provider network so that we can develop an interconnected network of physicians who are experienced in treating SCD.

- Identifying educational opportunities for PCPs, which includes information on how to manage members with SCD (e.g., use of Hydroxyurea, penicillin and Transcranial Doppler [TCD] screening). PCP education is critical to providing PCPs the knowledge they need to successfully manage the care of members with SCD. For example, TCD screening is a covered benefit that screens for the risk of a stroke. The results of the screening allow the provider to conduct interventions, such as regular blood transfusions, to minimize stroke risk.
- Developing a Louisiana-specific advisory panel that will be made up of non-clinical members, such as community organizations and caregivers, to understand the unique needs of Bayou Health members.
- Working to establish an SCD Center of Excellence in Louisiana, consisting of local providers and specialists with expertise managing members with SCD. This center of excellence will work to improve the care and management of Bayou Health members with SCD.

Ongoing sickle cell program interventions include:

- Ongoing evaluation and risk stratification
- Creating, updating, communicating and managing a person-centered plan of care
- Periodic member assessment
- Monitoring and managing ER and inpatient admissions and readmissions
- Coordinating access to appropriate support services both inside and outside of the system
- Member, caregiver, physician education
- Member advocacy throughout all stages of the care continuum

Once implemented, our Louisiana SCD program will enhance our person-centered model of care by:

- Identifying members with SCD who are at risk for ER use and inpatient admissions (e.g., members experiencing recurring pain crises). We identify members through:
  - Analysis of claims and clinical data and risk stratification using Impact Pro.
  - The new-member welcome call and HRA. For members identified with SCD through the HRA, we refer them to our SCD clinical team for a comprehensive sickle cell assessment to identify member needs and their risk level.
- Engaging high-risk members in case management through collaboration between the members' PCP and a case manager with expertise in managing members with SCD or enrollment in an Accountable Care Community (ACC) practice with SCD expertise. For ACC practices without this expertise, our SCD case manager will partner with the ACC practice to manage the member's care.
- Implementing a "feet-on-the-street" model to increase member engagement. Our SCD case manager and community health workers will conduct member engagement-related activities. Partnerships with community-based organizations that support SCD members will help to increase member engagement.
- Engaging providers and members at clinics, hospitals, schools and community events to provide education, develop relationships and connect members to community resources.
- Implementing local, field-based SCD experts, supported by telephonic experts who help find members, conduct the sickle cell assessment, identify gaps in care and resolve barriers to care, such as transportation).
- Coordinating with behavioral, pharmacy and other services, such as Healthy First Steps.

- Ensuring development of an effective, person-centered plan of care to reduce pain and manage symptoms, including short and long-term goals.
- Ensuring members have a pain management plan to manage their daily pain levels so they are not visiting the emergency room or admitting themselves into the hospital.
- Providing member/caregiver education and support, such as use of Hydroxyurea; managing daily life functioning; coping with cognitive functioning issues; understanding how to speak with providers; transitioning to adult condition management, including managing their own care; and empowering members to get what they need to manage their condition from their provider.

Community-Based Outreach

In addition to the proposed Sickle Cell Disease Management and Outreach program described above, we will continue to build on the programs we have in place within the state. Described below are four unique programs that we have developed for Bayou Health members that address the social, cultural and economic needs of a broad range of community members and that illustrate our commitment to supporting the community. These include:

- The support of a Whole Child program that addresses the root causes of the student achievement gap by providing comprehensive health assessments for children including eliminating EPSDT gaps in care.
- A program for seniors that addresses the need for basic services through Meals on Wheels and which provides wellness and activity support through the UnitedHealthcare Aquatic Center in East Baton Rouge and a similar program in Ouachita Parish that provides meals for disadvantaged seniors.
- Primary support for two fitness and youth engagement programs in North and Central Louisiana that will reach an audience of 30,000 youth statewide to promote health awareness and physical fitness.

Childhood & Family Learning Foundation
Focus Area: EPSDT and Children's Health

Childhood & Family Learning Foundation (CFLF) represents child advocates, educators and service providers throughout New Orleans. CFLF tries to **address the very root causes of the student achievement gap by providing comprehensive health assessments for the children**, then based upon the findings, leading health care providers and faculty offer targeted services to help each individual child thrive physically and thus academically. We have partnered with CFLF to create a pilot program to increase access to health care for children and youth. Our investment will support the creation of a Whole Child program to provide quality health programs and outcomes for children.

East Baton Rouge Council on Aging
Focus Area: *Aging and Seniors*

East Baton Rouge Council on Aging (EBRCOA) provides services for approximately 6,000 seniors in the Baton Rouge area. The agency provides meals to hundreds of seniors daily, transportation, programs, access to health and social supports, and assistance to those in need. **UnitedHealthcare and EBRCOA have collaborated to support the now named "UnitedHealthcare Aquatic Center" and Meals on Wheels programs.** The Aquatic Center provides wellness and activities support for seniors. The Meals on Wheels program provides 125,000 meals annually to needy members of the Baton Rouge community. This unique partnership provides exposure, community awareness, educational materials and services to support the senior community in East Baton Rouge Parish.

Ouachita Parish Council on Aging (OPCOA)
Focus Area: *Aging and Seniors*

Ouachita Parish Council on Aging (OPCOA) serves seniors throughout Ouachita parish and surrounding area. OPCOA offers Meals on Wheels services through the use of seven food vans providing delivered and on-site food distribution to approximately 300 seniors every day. The Ouachita Parish area is comprised mainly of poor communities and needy seniors. OPCOA is challenged to be able to support a large community of seniors with limited funding and support. Additionally, OPCOA has significant transportation challenges with little financial support. We have partnered with OPCOA to sponsor their Meals on Wheels program serving the seniors of Northeast Louisiana. **Our support reaches hundreds of seniors in the community who would normally not receive a hot and nutritious meal delivered to their front door.**

Youth Obesity Understanding for Training & Health
Focus Area: *Diabetes, Obesity, EPSDT and Children's Health*

The challenge of childhood obesity and physical activity is prevalent in youth today. Regular physical activity in childhood and adolescence improves strength and endurance, helps build healthy bones and muscles, helps control weight, reduces anxiety and stress, increases self-esteem, and may improve blood pressure and cholesterol levels. We will support two fitness and youth engagement programs in North and Central Louisiana. Each year-long program used the impact and respect demanded by **NBA star and Baton Rouge native Glenn 'Big Baby' Davis and Shreveport's own Fit4Life's Robert 'Superman' Blount.** We will be the primary sponsor of programs designed to support youth with health awareness and physical fitness. Combined these programs reach a captivated audience of 30,000 youth throughout the state of Louisiana. Each program provides exercise opportunities and focuses on fitness, healthy lifestyle tips and positive exposure for area youth.

Part VII: Quality Management

Section U: Quality Management

U.1 Declare whether or not the proposer submitted HEDIS measures in measurement year 2013. Indicate whether the measures were reported for a State Medicaid, CHIP, and/or Commercial product line. Five points will be awarded to proposers with this experience reporting HEDIS measures. (5 points)

Experience Reporting HEDIS Measures

UnitedHealthcare submitted blended Medicaid/CHIP rates to DHH as required for our Bayou Health CCN-S contract and as specified in our response to Question E.5, Experience and Qualifications. We also submitted HEDIS measures for measurement year 2013 (reporting year 2014) to NCQA for reporting in Quality Compass and for the purpose of maintaining the accreditation of our Medicaid and commercial products in the state of Louisiana. We were successful in achieving accreditation in July 2014.

We have extensive national experience tracking, reporting, and improving HEDIS measures across our organization. In total, for 2014 (care rendered in 2013), we completed 15 Medicaid health plan HEDIS submissions, 86 commercial submissions, and 158 Medicare submissions. All submissions were deemed reportable by our external, NCQA-certified HEDIS auditor, indicating our administrative and medical record data collection methods are accurate and robust.

UnitedHealthcare has been in operation since February 2012. We reported to DHH admin-only rates for HEDIS 2013 (CY 2012) then reported both admin and hybrid for HEDIS 2014 (CY 2013).

We agree to comply with each specification and requirement outlined in Section 14.2 including the reporting of performance measures (Section 14.2.5) for Bayou Health program members.

U.2 Complete appendix WW, **HEDIS Scoring Tool** by submitting the Proposer's results for the HEDIS measures specified below for measurement year 2013, for each of your State Medicaid contracts listed in response to E.1.

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

Include the Proposer's legal business name, as defined by L.R.S.12:23, AND the product line name or dba.

If the average of seven or more measures for state Medicaid contracts is above the 2013 NCQA HMO National 50th Percentile for Medicaid Product Lines, ten points will be awarded.

If the average of all measures for state Medicaid contracts is above the 2013 NCQA HMO National 25th Percentile for Medicaid Product Lines, five points will be awarded. No points will be awarded if all measures do not meet at least the 2013 NCQA HMO National 25th Percentile for Medicaid Product Lines.

DHH Reserves the right to independently verify all information provided in Appendix WW. (10 points)

We have provided Appendix WW_HEDIS Scoring Tool, as Attachment U.2-1 and the IDSS Template as Attachment U.2-2_HEDIS 2014 IDSS Template – LA Medicaid.

In appendix WW_HEDIS Scoring Tool, we have listed the 15 UnitedHealthcare Medicaid State contracts (also included in E.1) that were publically reported to NCQA for the 2013 reporting year. Publically reported data are included in benchmark calculations and in the Quality Compass release. There are several reasons why plans may not publically report HEDIS data such as, but not limited to, a state may calculate their own HEDIS rates or a state may leverage different populations for evaluation.

The contracts listed in E.1 that were not included in the appendix include Medicaid contracts whose HEDIS data was not submitted to NCQA, new Medicaid contracts (contracts not eligible to be reported until there is at least one full calendar year of eligibility), expired/discontinued contracts, CHIP contracts (NCQA does not publish CHIP HEDIS data) and Medicare Advantage Dual Special Needs Plans.

As noted in Appendix WW_HEDIS Scoring Tool, a total of **10 measures' averages are above the 2013 NCQA HMO National 50th Percentile for Medicaid product lines.** The average of all measures for state Medicaid contracts is above the 2013 NCQA HMO National 25th Percentile for Medicaid product lines.

We agree to comply with each specification and requirement outlined in Section 14.2 including the reporting of performance measures (Section 14.2.5) for Bayou Health members.

U.3 Document experience in other States or previous Louisiana Medicaid managed care experience
Describe experience in using results of performance measures, member satisfaction surveys, and other data will be used to drive changes and to positively impact the healthcare status of Medicaid and or CHIP populations. Provide an example of changes implemented as a result of data collection to improve the health outcomes of your membership in Louisiana or another state Medicaid program. Examples of areas of interest include, but are not limited to the following:

- Management of high risk pregnancy
- Management of HIV
- Sickle cell disease management
- Reductions in low birth weight babies
- Pediatric Obesity (children under the age of 19)
- Reduction of inappropriate utilization of emergent services
- Children with special health care needs
- Asthma
- Diabetes
- Cardiovascular diseases

- Reduction in racial and ethnic health care disparities to improve health status
- Hospital readmissions and avoidable hospitalizations
- Reduction in incidence of sexually transmitted infections (20 points)

Improving the Lives of Medicaid Members

CAHPS Rating is High Among Adults
Bayou Health performed well on the Adult CAHPS 2013 survey, scoring above the NCQA average on six of the eight key measures, including Overall Rating of the health plan. 86 percent of members surveyed rated the health plan at least an 8 on a scale from 0 to 10 (75th percentile). **This was the highest percentage of any Bayou Health Plan.**

Aligned with CMS's agenda for quality and the Institute for Healthcare Improvement's Triple Aim, the framework of our Quality Management Program is designed to improve patient experience of care (e.g., quality, access, satisfaction), to improve the health of populations, and to reduce the per capita costs of health care. Our Quality Management Program overseen by chief medical officer Dr. Ann Kay Logarbo and quality management coordinator Angela Olden is designed to objectively monitor, systematically evaluate, and effectively improve the quality and safety of clinical care and quality of services provided to Bayou Health program members.

We have performed well in Louisiana on both the Adult and the Child CAHPS 2013 survey. For instance, the Child CAHPS 2013 survey scored above the NCQA average on seven of the eight key measures, including Overall Rating of the Health Plan. 86.09 percent of members surveyed rated the health plan at least an 8 on a scale from 0 to 10 (75th percentile). This was also the highest rating among all Bayou Health plans.

Driving Improved Health Outcomes in Louisiana

Our quality improvement program is designed to rely upon consistent, evidence-based practices that positively impact the health care status of Bayou Health members. Through systematic, data driven processes we continuously monitor, evaluate and seek to improve our approaches, methods and, ultimately, member health outcomes. We use performance improvement projects and quality improvement projects to assess performance, develop studies and act on improvements. Our model is rapid cycle improvements following a Plan, Do, Study, Act approach.

Data Collection, Monitoring and Benchmarking

The monitoring of quality indicators is designed to reveal trends and performance opportunities in specific areas and facilitate plan-wide improvement. To this end, a variety of care and service indicators to monitor are derived from as many sources as appropriate including HEDIS and CAHPS. The quality indicators are measurable, based on research, and use current and accepted data collection and analytical methodologies. Topics for routine monitoring and focused activities are chosen based on the demographic and epidemiological characteristics of the population. Examples of monitoring indicators may include tracking and trending of inpatient or outpatient acute or chronic conditions, access performance measurements, customer and claims service, member satisfaction or unique specific indicators as identified from local epidemiology or demographics.

We establish quantifiable indicators which clearly and accurately measure the activity being evaluated. Indicators measure changes in health or functional status or member satisfaction.

Baseline benchmarks and goals are set along with information on how the benchmarks and goals were derived. In addition, process measures are established and evaluated as applicable to verify that interventions are being implemented and progressing as planned.

Identification of Opportunities to Improve Healthcare Status

Quality Improvement activities are designed to objectively and systematically monitor and evaluate opportunities aimed at improving the quality, timeliness and appropriateness of care and service provided to our members.

As part of our Quality Improvement Program, we use a variety of established tools to help support our strategic objectives and ultimately our mission to help people live healthier lives. Such tools include the Plan-Do-Study-Act cycle, Six Sigma, and Rapid Cycle Improvement. These methodologies are problem-solving techniques that we apply to specific and measurable performance indicators. Quality improvement methodologies are supported by a variety of experts across the Quality Management and Performance organization, including a team of seven Six Sigma Black Belts, and regional support that includes two Certified Professionals in Healthcare Quality.

Implementing Change

UnitedHealthcare, as an incumbent Bayou Health plan and as a nationwide provider of Medicaid managed care services, has extensive experience in both Louisiana and other states improving performance and ultimately the health outcomes of Medicaid beneficiaries. Below, please find examples of changes implemented as a result of data collection, monitoring and benchmarking of key quality indicators relevant to the quality of care rendered to our members.

Management of High Risk Pregnancy

Areas of Interest and Program Description: Prenatal and Postpartum Care, and Frequency of Prenatal Care		
State/Population Type: UnitedHealthcare Community Plan of Louisiana Medicaid Population **Performance Measures Used: Prenatal Care and Frequency of Prenatal Care**		
Opportunity Identification and Description	**Changes Implemented**	**Outcomes**
Timely and routine prenatal care is critical to the health of the mother and the baby, particularly in the case of high risk pregnancies and when working to prevent low birth weight babies. In 2013, we calculated baseline unaudited HEDIS rates for critical measures in the state, including the Frequency of Ongoing Prenatal Care measure. This measure indicates the percentage of women receiving greater than or equal to 81 percent of the expected prenatal care visits. Our unaudited initial rate was 60.1, indicating performance below the national NCQA 50th percentile.	We implemented a comprehensive program to support women in obtaining timely and appropriate prenatal care. This program encompassed UnitedHealthcare programs and resources and community programs and resources. Coordinated through our maternal case management program, Healthy First steps, we engaged pregnant members educating them on the availability of services through UnitedHealthcare, their OB/GYN and PCP and in the community including: **Healthy First Steps** UnitedHealthcare's maternal case management program with the goals of decreased NICU admissions, lengths of stay and readmissions; member engagement to change behaviors and promote healthy lifestyle; reduced incidence of premature and low birth weight deliveries and improved quality measures **Nurse Family Partnership (NFP)** An evidence-based home visitation model for Medicaid eligible first-time mothers and their families. For enrolled clients, nurse visits begin in the first or second trimester of pregnancy, and continue until the child turns 2 years old. Nurses provide education, support and guidance to help women have a healthy pregnancy and care for their baby. **Partners for Healthy Babies** Partners for Healthy Babies is a project of DHH's Bureau of Family Health and WIC program. The project serves to provide information and resources to women and their families via toll-	We compared our 2014 and 2013 (baseline) HEDIS performance. Our 2014 rate of 73.48 surpassed the NCQA South East Region 75th percentile and nearly surpassed the 75th National percentile. This represents an improvement of over 13 percentage points over our 2013 baseline rate. Ongoing analysis of our performance continues to uncover opportunities to address health disparities and drive continuous improvement. We continue to implement changes to drive improved outcomes for pregnant Bayou Health members as described in Sections I and K of this proposal in Sections I and K of this proposal.

Areas of Interest and Program Description: Prenatal and Postpartum Care, and Frequency of Prenatal Care		
State/Population Type: UnitedHealthcare Community Plan of Louisiana Medicaid Population **Performance Measures Used: Prenatal Care and Frequency of Prenatal Care**		
Opportunity Identification and Description	**Changes Implemented**	**Outcomes**
Timely and routine prenatal care is critical to the health of the mother and the baby, particularly in the case of high risk pregnancies and when working to prevent low birth weight babies. In 2013, we calculated baseline unaudited HEDIS rates for critical measures in the state, including the Frequency of Ongoing Prenatal Care measure. This measure indicates the percentage of women receiving greater than or equal to 81 percent of the expected prenatal care visits. Our unaudited initial rate was 60.1, indicating performance below the national NCQA 50th percentile.	free helpline (800) 251-BABY (2229) and its website. **LaHART** LaHART was created by the DHH's Birth Outcomes Initiative to streamline the screening and referral process for pregnant Medicaid eligible women in need of treatment for substance use during pregnancy. The Louisiana Health Assessment Referral & Treatment (LaHART) web-based tool is now available to screen pregnant Medicaid patients for tobacco, alcohol, drug abuse as well as domestic violence. Louisiana providers are now paid $50 for conducting prenatal behavioral health screening and brief intervention with their Medicaid patients. **Strong Start** The Strong Start initiative focuses specifically on the impact of non-medical prenatal interventions that, when provided in addition to routine obstetrical medical care, are believed to reduce rates of preterm births. **Louisiana Fetal Infant Mortality Review (FIMR)** The Fetal-Infant Mortality Review (FIMR) Program is an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants and families. **39 Week Initiative** DHH and several partners seek to end non-medically indicated deliveries prior to 39 weeks gestation in Louisiana's birthing hospitals. Birth Outcomes Initiative has partnered with the Louisiana State Medical Society, the Louisiana Hospital Association, and the Louisiana Chapter of the	We compared our 2014 and 2013 (baseline) HEDIS performance. Our 2014 rate of 73.48 surpassed the NCQA South East Region 75th percentile and nearly surpassed the 75th National percentile. This represents an improvement of over 13 percentage points over our 2013 baseline rate. Ongoing analysis of our performance continues to uncover opportunities to address health disparities and drive continuous improvement. We continue to implement changes to drive improved outcomes for pregnant Bayou Health members as described in Sections I and K of this proposal in Sections I and K of this proposal.

Areas of Interest and Program Description: Prenatal and Postpartum Care, and Frequency of Prenatal Care		
State/Population Type: UnitedHealthcare Community Plan of Louisiana Medicaid Population **Performance Measures Used: Prenatal Care and Frequency of Prenatal Care**		
Opportunity Identification and Description	**Changes Implemented**	**Outcomes**
Timely and routine prenatal care is critical to the health of the mother and the baby, particularly in the case of high risk pregnancies and when working to prevent low birth weight babies. In 2013, we calculated baseline unaudited HEDIS rates for critical measures in the state, including the Frequency of Ongoing Prenatal Care measure. This measure indicates the percentage of women receiving greater than or equal to 81 percent of the expected prenatal care visits. Our unaudited initial rate was 60.1, indicating performance below the national NCQA 50th percentile.	American College of Obstetricians and Gynecologists (ACOG) to facilitate hospital sign on to the Secretary's 39 week letter. **LaPRAMS (A part of FIMR)** (LaPRAMS) Louisiana Pregnancy Risk Assessment Monitoring System. LaPRAMS is an ongoing, population-based risk factor surveillance system to describe select maternal behaviors and experiences that occur before and during pregnancy, as well as during a child's early infancy. **LaPAMR** Louisiana Pregnancy-Associated Mortality Review (LaPAMR) - LaPAMR determines the causes of maternal mortality and makes recommendations concerning quality improvement opportunities in maternity care and public health strategies to prevent maternal deaths in Louisiana **End of Pregnancy Reports** Reports generated and provided to DHH on a bi-weekly basis pinpointing the number of claims made by a member for any end of pregnancy related diagnoses **Provider Outreach** UnitedHealthcare developed an outreach program to educate Obstetricians on services available to mutual members/patients inclusive of Healthy First Steps (HFS) case management process (OBRAF), 17P process, LaHART, etc. to ensure a continuum care coordination. Literature about HFS is provided to the practice to help educate members about the program.	We compared our 2014 and 2013 (baseline) HEDIS performance. Our 2014 rate of 73.48 surpassed the NCQA South East Region 75th percentile and nearly surpassed the 75th National percentile. This represents an improvement of over 13 percentage points over our 2013 baseline rate. Ongoing analysis of our performance continues to uncover opportunities to address health disparities and drive continuous improvement. We continue to implement changes to drive improved outcomes for pregnant Bayou Health members as described in Sections I and K of this proposal in Sections I and K of this proposal.

Management of High Risk Pregnancies

Areas of Interest and Program Description: Healthy Babies and Elective Deliveries		
State/Population Type: Louisiana Medicaid **Performance Measures Used: Elective Deliveries <39 weeks**		
Opportunity Identification and Description	**Changes Implemented**	**Outcomes**
Deliveries between 37 and 38 weeks gestation have increased dramatically from 19.7 percent of all live births in 1990 to 28.9 percent in 2006. The concomitant rise in deliveries between 37 and 39 weeks has been associated with an increase in obstetrical interventions such as induction of labor and cesarean sections. Given this national trend, the opportunity to improve outcomes, and in alignment with DHH, we instituted a baseline measurement and barrier analysis for our Plan. This has been rolled into an ongoing performance improvement project and we will track our performance toward sustained improvement.	**Healthy First Steps Outreach** Ensured HFS maternal management group scripting for member outreach includes education on the State's 39 week initiative and the benefits of full-term deliveries as opposed to early elective deliveries. **Provider Education and Support** Disseminated materials to PCPs to share with members identified as pregnant. Developed and implemented scripting for providers on the benefits of full-term deliveries as opposed to early elective deliveries used as part of the provider outreach conducted by the EPSDT/maternal management coordinator. Included articles about the benefits of full-term deliveries as opposed to early elective deliveries in member and provider newsletters. **Text4Baby** Ensured that Text4Baby scripting included information about the benefits of full-term deliveries as opposed to early elective deliveries. **Community-based Collaboration** Ascertained community partner knowledge of the 39 week initiative and engaged their assistance, specifically, the Nurse Family Partnership and Healthy Start. Identified other potential partners. **School-based Health Center Partnerships** Identified resources and developed education materials on the benefits of full-term deliveries as opposed to early elective deliveries for use in school-based health centers. Distributed	Our baseline measurement of 58.6 percent rate of non-medically indicated (elective) deliveries shows that opportunities exist for increasing compliance with the State's 39 week initiative. Further drill down of the data show that there may be differences in adherence at a facility level presenting opportunities for focused provider education. Our initiatives have been implemented and will undergo our routine effectiveness evaluation process. Should the program not yield the anticipated improvement, it will be modified, ultimately ensuring the continuous quality improvement cycle is resulting in improvement for this important public health issue.

Areas of Interest and Program Description: Healthy Babies and Elective Deliveries		
	materials or resources to the health centers. **Priority Outlier Facility Engagement** Identified facilities that are outliers with respect to gestational age at delivery and facilitate the development and implementation of improvement plans for improving adherence to the 39 week initiative.	

Pediatric Obesity

Areas of Interest and Program Description: Pediatric Obesity – YMCA/Church Wellness (children under the age of 19)		
State/Population Type: Tennessee Medicaid **Performance Measures Used: Weight Loss**		
Opportunity Identification and Description	**Changes Implemented**	**Outcomes**
Lifestyle Improvement for Members: YMCA Program and Church Health and Wellness for Weight Loss According to the Tennessee Obesity Task Force, Tennessee is rated third in the nation in pediatric and adult obesity. More than three million Tennesseans are overweight or obese and, as a result, are at greater risk for chronic health conditions. In reviewing our Tennessee Health Plan data on the prevalence of obesity diagnoses as well as frequency of BMI assessment, we identified the need to initiate a program to address barriers faced by health care providers and members that contribute to this problem.	In middle and west Tennessee, we partner with fitness facilities to offer lifestyle change opportunities for members. In middle Tennessee, we partner with YMCA of Middle Tennessee to offer fitness and facility memberships to both children and adults who are obese. Adult program members are required to attend a minimum of 12 times per month to maintain membership. There is no attendance requirement for children. We know that engagement in fitness programs such as the YMCA will lead to improved physical and emotional health for our members. At present, the YMCA of Middle Tennessee includes 36 facilities across the region (the number of sites changes frequently as new facilities are added). Members may use any of the 36 facilities located in the Middle Tennessee region. In west Tennessee, we partner with Church Health and Wellness Center in downtown Memphis to offer nutrition education and fitness opportunities for our members. Offering above and beyond a traditional fitness facility membership, Church Health and Wellness also provides a required nutrition class, Healthy Bodies, for participating members. In addition, members with certain chronic conditions (such as diabetes and heart failure) are also required to take specific nutrition and educational classes to maintain their membership in the program. Church Health and Wellness also offers interactive activities such as nutritional cooking classes and a weekly farmers market from May through September each year.	In 2012, 834 members were enrolled in the middle Tennessee YMCA program. The program averages around 115 members actively working out each month. **Average weight loss is 5.6 pounds each month for adult members.** The YMCA program has been so successful that we are doubling the number of memberships available (from 150 to 300). We identified an opportunity to further support our pediatric members in participating as many The YMCA program has not been as successful in the engagement of obese children, as many children do not have transportation to gain access to the YMCA facilities. To provide an option that would overcome this barrier, we began offering our Childhood Obesity Programs in 2012, as described in the next row of this table. Approximately 289 members were enrolled in the Church Wellness program in 2012. The program averages around 70 members actively working out each month. **Average weight loss is 6.5 lbs. per member per month.** To allow for additional participation, we are doubling the memberships available (from 150 to 300). We have received great feedback from members and facility directors regarding our lifestyle improvement programs.

Pediatric Obesity

Areas of Interest and Program Description: Pediatric School Based Obesity Program (children under the age of 19)		
State/Population Type: Tennessee Medicaid **Performance Measures Used: Weight Loss**		
Opportunity Identification and Description	**Changes Implemented**	**Outcomes**
Lifestyle Improvement for Members: Childhood Obesity Program As described above, our Church Wellness and YMCA programs have been well received and successful in helping members lose weight. However, as noted during our ongoing barrier analyses, children without transportation weren't able to fully participate. Subsequently, we added additional programs.	To provide a school-based lifestyle engagement opportunity for our young members (and negate the transportation barrier cited above), we work with two vendors, AOYA (Athletic Odyssey Youth Association) and Healthy Kids and Teens, to offer 12-week after-school sessions for children. Classes offer both physical and nutritional education. Each session includes a parental component to educate families as well. Vendors work with Tennessee Coordinated School Health to allow the health plan to hold these classes at school locations across the State. AOYA is based in middle Tennessee and is offered in four schools per semester. Healthy Kids and Teens programs are offered in east and west Tennessee in a total of nine schools per semester (five in west Tennessee, four in east Tennessee).	Currently, **each child in the program is averaging a weight loss between 5.3 and 5.6 lbs.** While weight management interventions do not directly impact HEDIS measures, we know they will have strong overall impact on numerous quality measures related to chronic disease, behavioral health and prevention. These programs also provide children with a safe, healthy after-school activity. Chances for long-term lifestyle change success are improved by offerings for parents/families as well.

Reduction of Inappropriate Utilization of Emergent Services

Areas of Interest and Program Description: Reduction of Inappropriate Utilization of Emergent Services		
State/Population Type: Louisiana Medicaid **Performance Measures Used: Ambulatory care ED visits**		
Opportunity Identification and Description	**Changes Implemented**	**Outcomes**
UnitedHealthcare analyzes our overall ER utilization and then performs a root cause analysis to identify specific areas to focus performance improvement. In reviewing inappropriate use of the ER in our population, the issue of asthma control emerged as a root cause for potentially avoidable ER use. In 2009, 44 percent of children	**Asthma Clinical Practice Guidelines** Asthma clinical practice guideline availability on the provider portal confirmation. Asthma Clinical Guidelines Training, including education on peak flow meters, nebulizers, medication and asthma action plans, performed at Children's Hospital in New Orleans.	Through November 2013, 53 children were enrolled in intensive asthma case management programs. For each child, costs were compared for the period six months prior to enrollment in a program and for the period six months after enrollment in the program. These costs were then aggregated and

Areas of Interest and Program Description: Reduction of Inappropriate Utilization of Emergent Services		
with asthma enrolled in Louisiana Medicaid visited the ER. With adequate asthma control preventing trips to the ER, the estimated opportunity, then, for reducing emergency room visits is 44 percent of 3,600 or 1,584 visits. With this assessment as part of the barrier analysis, we initiated a program to address use of the ER by members with asthma.	State approval of case management member education materials for asthma management **Certified Asthma Educators** Results were shared with DHH in December 2013 as a demonstration of the value of certified asthma educators. UnitedHealthcare asked DHH to consider certified asthma educators as a Medicaid benefit. **Asthma Super-Utilizers** Our Lady of the Lake (OLOL) initiated an asthma disease management program. UnitedHealthcare partnered with OLOL to identify OLOL top asthma ER and inpatient utilizers for referral to their program. Provided a list of the top 10 asthma utilizers to OLOL CAMP program for aggressive management. Identification of top 1 percent of members with high ER visits and inpatient admissions for referral to case management. **Asthma Continuing Medical Education Credit** Over 30 PCPs including residents, staff physicians, and nurse practitioners attended and earned continuing medical education (CME) credit. DHH is holding quarterly asthma education events across the State. Collaboration with DHH and Children's Hospital to sponsor CME credit on current standards of care for asthma. **ER Coach Pilot** Data include ER diagnosis, admit and discharge information. Low level ER diagnoses are routed to an ER health coach who attempts for 48 hours post ER visit to contact the member and discuss alternatives to ER visits, such as contacting NurseLine, visiting the PCP, or going to an urgent care facility, if needed. The use of the ER is stressed as a source for	classified into four categories: ER visits, inpatient (IP) admissions, PCP visits and prescriptions (Rx). Overall, costs were lower post-enrollment versus pre-enrollment. IP costs were significantly lower ($34,474 pre-enrollment versus $8,963 post-enrollment, a statistically significant difference) and PCP visit and Rx costs were higher, which are all indicators of well managed patients with asthma ($6,593 pre-enrollment versus $8963 post-enrollment for PCP visits and $33,398 pre-enrollment versus $49,673 post-enrollment for Rx, both differences are statistically significant) ER costs were slightly higher ($4,724 versus $5,566, not a statistically significant difference), which is not the desired outcome, so further analysis was conducted to understand the cause. Of the $5,566 of post-enrollment ER costs, over $3,200 were incurred by two children. Neither child had post enrollment PCP visits or medication compliance. We will continue to approach high ER utilization by identifying conditions which, with good medical management, can be stabilized and subsequently the number of ER visits can be reduced.

Areas of Interest and Program Description: Reduction of Inappropriate Utilization of Emergent Services		
	emergency care only. In the first six months of 2013, of 354 members identified, 78 (22 percent) were reached. **NurseLine** NurseLine is available 24 hours a day, seven days a week to members to assist with recommending appropriate levels of care. In 2012, of the 4,721 calls triaged by the NurseLine clinicians, 49 percent of the recommendations were to contact a physician, 31 percent were to apply home care, and 7 percent were to proceed to an urgent care facility. In 2013, of 3,240 calls triaged by the NurseLine clinicians, 46 percent of the recommendations were to contact a physician, 25 percent were to apply home care, and 8 percent were to proceed to an urgent care facility.	

Asthma

Areas of Interest and Program Description: Asthma		
State/Population Type: Michigan Medicaid **Performance Measures Used: Use of Appropriate Medications for People with Asthma**		
Opportunity Identification and Description	**Changes Implemented**	**Outcomes**
Michigan Asthma Care Coordination and Incentive Program In 2012, our Michigan Plan measured and benchmarked their performance on the HEDIS Use of Appropriate Medications for People with Asthma measure. Their rates did not meet their stated goals, particularly for ages 12-18 at 79.83, and subsequently an improvement initiative was implemented.	To coordinate care for and incentivize appropriate care and treatment for children with asthma, our Michigan health plan implemented the following program: ▪ $20 gift card member incentive for members who sought and received appropriate care and treatment. ▪ $100 gift card provider incentive to providers who rendered the appropriate care and treatment, including medication management. ▪ Registered nurse reaches out to non-adherent asthmatics for all asthma HEDIS measures (ASM) measures to educate on persistent asthma, medication management, self-management and assists with care coordination. Nurse provides PCP office with list of non-compliant members to help office to easily identify non-compliant members. This initiative works in tandem with care coordination that addresses member educational issues, benefit discussions, PCP changes, transportation appointments, doctor appointments.	Between 2012 and 2014, our Michigan health plan has shown a **7 percentage point improvement in appropriate medications for children with asthma ages 12 to 18 years old, bringing their rate to the 50th percentile at 86.45.**

Diabetes and Reduction in Racial and Ethnic Health Care Disparities to Improve Health Status

Areas of Interest and Program Description: Diabetes and Ethnic Health Care Disparities		
State/Population Type: Florida Medicaid **Performance Measures Used: HbA1c Screening**		
Opportunity Identification and Description	**Changes Implemented**	**Outcomes**
Management of diabetes mellitus, including the important component of HbA1c testing, was selected to study the cultural and linguistic disparities among Medicaid members enrolled with UnitedHealthcare Community Plan of Florida. Specifically, the project was designed to identify and address disparities in the management of diabetes mellitus and glycohemoglobin (HbA1c) testing between English-speaking and Spanish-English-speaking members. For the baseline, of the eligible members identified using administrative HEDIS 2006 data, 1,417 diabetic members, 23 percent (331) were Spanish-speaking versus 77 percent (1,086) English-speaking members. This represents a 4:1 ratio - nearly four English-speaking diabetic members for every Spanish-speaking diabetic member. This was also consistent with the ethnicity/language proportions reported by the US Census for Florida. For the baseline measurement, 52.67 percent of the English-speaking population received an HbA1c test, versus 34.74 percent of the Spanish-speaking members. Subsequently, a long term improvement project was implemented.	Provider outreach with diabetes education materials and documentation tools Distribute Non-Compliant List to providers via clinical practice consultant (CPC). Improve reporting of HbA1c testing and results from lab vendor to monitor poor HbA1c management and high LDL levels and provide PCPs with members needing additional clinical management. "HEDIS in a Box"- This user-friendly pocket guide designed specifically for PCPs offers an at-a-glance, checklist-type reference for the recommended adult and pediatric preventive health services and summarizes the HEDIS requirements for each measure. Universal Tracking Database (UTD) - provides easily accessible info on member and provider compliance with utilization of diabetes-related maintenance services and allows the health plan to target specific populations and/or HEDIS measures (such as Comprehensive Diabetes Care – CDC).	Between 2006 and 2013, data on screening was analyzed for the population as a whole and for English- and Spanish-speaking members. Overtime, With member and provider education the study concluded that management of diabetes, specifically, HbA1c testing appears to be slightly better among the Spanish-speaking membership. This was noticeable across all measurements. In the final re-measurement, the final rates indicated more Spanish-speaking members were receiving the testing. The difference in **rate of HbA1c testing between English-speaking (76.19 percent) and Spanish-speaking (87.63 percent) diabetic members was statistically significant (p = 0.0001).** The robust, ongoing interventions in place are attributed for the meaningful, statistically significant, overall improvement in HbA1c testing among English-speaking as well as Spanish-speaking diabetics. The improvement from baseline to the final re-measurement was even more pronounced among the Spanish-speaking members confirming that the addition of member-focused education materials in Spanish reduced the cultural and linguistic disparities in the management of diabetes, mainly, HbA1c testing.

Reduction of Sexually Transmitted Diseases

Areas of Interest and Program Description: Chlamydia Screening		
State/Population Type: Louisiana Medicaid **Performance Measures Used: Chlamydia Screenings**		
Opportunity Identification and Description	**Changes Implemented**	**Outcomes**
In 2013, we calculated baseline unaudited HEDIS rates for critical measures in the state, including the Chlamydia Screening measure. Our unaudited initial rate was 50.7, indicating performance below the national NCQA 25th percentile. This resulted in a quality improvement program to increase the percentage of women who are screened for chlamydia as part of their routine preventive care.	Activities include provider education through our CPC program, member outreach by our health promotion coordinator and educational materials.	UnitedHealthcare has shown via our internal tracking a month-over-month increase in our chlamydia screening rates, ultimately resulting in a rate of 53.66 percent for our final reported rate in June 2014. **August 2014 interim rates compared to August 2013 indicate continued improvement, with an increase of over 8 percentage points from this time last year.** We encourage DHH to take into consideration the Sensitive Health Information (SHI) laws enacted in 26 states that are additive to the Federal Laws under HIPPA. As measures and care are integrating behavioral and sensitive health conditions, the ability to provide information and continuity of care may be “restricted” in provisions that may require greater administrative burden to assure care for individuals. The Sensitive Information categories are: ▪ Sensitive information ▪ Behavioral/mental health ▪ Substance abuse ▪ STD ▪ HIV/AIDS ▪ Domestic violence ▪ Genetic information ▪ Reproductive health of minors and certain types of adult female reproductive health

We keep DHH informed of recommendations and outcomes by submitting quarterly updates and committee minutes as required. DHH receives copies of the QAPI Program Description, Work Plan and Annual Evaluation. We will continue to work collaboratively with DHH and do QAPI presentations as agreed upon, and discuss strategies to improve outcomes of the QAPI. We propose in 2015 that a DHH representative be a QAPI committee member and have an opportunity to view the QAPI in action with stakeholders.

U.4 Submit a preliminary description of your Quality Assessment and Performance Improvement Program (QAPI), as described in Section 14.1 of the RFP. Such description should address the following. Proposers may submit information from another state Medicaid program showing proposed adaptations to be made for the Louisiana population.

- Proposed membership of the QAPI Committee including roles and responsibilities
- Proposed QAPI Work plan including a detailed descriptions of how the QAPI Committee will work with the MCO leadership to monitor quality improvement work, specifically:
  - performance improvement projects;
  - medical record audits;
  - performance measures;
  - Plan-Do-Study-Act cycles or continuous quality improvement activities;
  - member and/or provider surveys; and
  - activities that address health disparities identified through data collection.
- Work the QAPI will undergo to improve the health care status of the Louisiana Medicaid population.
- Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.
- How the proposer will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner.
- How the proposed QAPIs may include, but is not necessarily, limited to the following:
  - New innovative programs and processes.
  - Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics or other non-traditional health care settings. (20 points)

Our Quality Assessment and Performance Improvement (QAPI) Program is designed to objectively monitor, systematically evaluate, and effectively improve the quality and safety of clinical care and quality of services provided to our Bayou Health members. Key attributes of our QAPI program include:

Local Oversight

- Oversight and approval of all QAPI activities by our Louisiana Board of Directors along with the executive leadership team, including but not limited to: chief executive officer April Golenor, chief medical officer Dr. Logarbo and interim behavioral health medical director Dr. Charles Freed
- Ability to leverage national programs and customize them to meet local cultural differences

Proven Results

- CAHPS: highest scores of all Louisiana Bayou Health Plans
- EQRO: compliance audit score of 99.23 percent
- HEDIS: received outstanding scores for all NCQA accreditation standards and guidelines for our Quality Management and Improvement program
- NCQA: As evidence of the strength of our QAPI structure and its components, in 2013 we received full credit for all standards and guidelines in the Quality Improvement chapter for NCQA accreditation:
  - QI1: Program Structure
  - QI2: Program Operations
  - QI3: Health Services Contracting
  - QI4: Availability of Practitioners
  - QI5: Accessibility of Services
  - QI6: Member Satisfaction
  - QI7: Complex Case Management
  - QI8: Disease Management
  - QI9: Practice Guidelines
  - QI10: Continuity and Coordination of Medical Care
  - QI11: Continuity and Coordination Between Medical Care and Behavioral Healthcare
  - **Quality Management and Improvement *Category Total*: 100 percent met**

We have contracted with the state of Louisiana since 2012 and our QAPI addresses the regulatory, contractual and accreditation needs of state of Louisiana and federal agencies in accordance with 42 CFR §438 and RFP section 14.1 requirements as well NCQA standards.

Our QAPI provides the structure, activities and initiatives for Bayou Health to provide the services necessary to meet the needs of our members and to continuously improve physical and behavioral health care outcomes. The QAPI promotes effective coordination of quality improvement activities with all appropriate functional areas, including, but not limited to: clinical operations, clinical services, customer service, appeals and grievance, disease management, case management, network management, quality management and performance, pharmacy, clinical analytics, legal, regulatory, claims and credentialing.

Each year we develop a specific Louisiana QAPI Work Plan which identifies planned activities related to program priorities that address the quality and safety of clinical care and service. Action steps include specific interventions with target dates for completion and identification of responsible oversight committees. Monitoring activities include tracking, and trending of identified issues, and planned interventions. The QAPI Work Plan is reviewed at least bi-annually by the Quality Management Committee (QMC).

Evaluation of the overall effectiveness of the QAPI is conducted annually to determine how well resources have been deployed to improve the quality and safety of clinical care and service provided to members. The QAPI Evaluation addresses all aspects of the quality improvement process as outlined in the Program Description and is presented to the Louisiana QMC and its board of directors for approval.

QAPI Goals and Objectives

The QAPI Program establishes goals and objectives that encompass the quality improvement activities with the local leadership team to ensure transparency and to synchronize the work with the state quality strategies. The program includes new innovative programs and processes as well as proven effective strategies. The 2015 objectives include:

- **Promote and incorporate quality into the organizational structure and processes.**
  - Facilitate a partnership between customers, practitioners, providers and health plan staff for the continuous improvement of quality health care delivery.
  - Continuously improve communication and education in support of these efforts.
  - Consider and facilitate achievement of Louisiana public health goals in the areas of health promotion, early detection, treatment and end of life care.
- **Provide effective monitoring and evaluation of patient care and services provided by contracted practitioners/providers as compared to the requirements of evidence-based medicine.**
  - Evaluate and disseminate clinical and preventive practice guidelines.
  - Monitor performance of practitioners and providers against evidence-based medicine.
  - Develop guidelines for quality improvement activities (e.g., access and availability, credentialing/re-credentialing and peer review).
  - Conduct and analyze data such as CAHPS and HEDIS, develop programs to improve satisfaction and preventive services as identified.
  - Provide chronic and complex case management programs that improve the quality of life for chronically ill members.
- **Ensure prompt identification and analysis of opportunities for improvement with implementation of actions and follow up.**
  - Implement and conduct continuous quality and performance improvement as opportunities are identified through analysis and high-risk, high-volume areas of patient care receive priority in selection.
  - Identify and monitor important aspects of, problems with, and concerns about health care services provided to members.
  - Identify and analyze existence of significant health care disparities in clinical areas.
  - Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language specific risks.
  - Provide ongoing feedback to our members and practitioners regarding the measurement and outcome of quality improvement activities.
- **Coordinate quality improvement, risk management, patient safety and operational activities.**
  - Aggregate and use data to identify potential gaps, opportunities for improvement and for the development of quality improvement activities.
  - Develop and implement a consistent process, by which risk management and patient safety are included in the development of quality improvement initiatives.
  - Monitor key aspects of patient safety, identify opportunities and develop programs to promote safe patient care.

- **Maintain compliance with local, state and federal regulatory requirements and accreditation standards.**
  - Monitor compliance with regulatory requirements for quality improvement opportunities and respond as needed.
  - Ensure that reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies.
- **Serve culturally and linguistically diverse populations and address health care *disparities through data collection***
  - We have made a commitment to improvements based on the needs of our changing member population. These improvements are expected to reduce health disparities by establishing the foundation for multicultural population stratification, understanding of health care needs across multicultural populations, driving/enforcing a patient centered approach and reducing health disparities across multicultural populations.
    - Goals include enhancing the spectrum of clinical programs to meet the diverse needs of our members, understanding the needs of the multicultural markets and modify programs and materials as needed.
    - Provide culturally competent member services and materials and ensure parity in access to quality care for all populations, including prenatal and postpartum care, attention deficit hyperactivity disorder (ADHD) prescribing, and other opportunities identified through data analysis or by DHH.
    - When analyzing results of QAPI activities we drill down to the demographic data to look for potential indicators of root causes that may be culturally of linguistically based. Data are stratified by sex, age, language, race/ethnicity and ZIP codes, Interventions are targeted to address any disparities found.

QAPI Committee Structure and Current Membership

UnitedHealthcare's QAPI demonstrates an inter-disciplinary approach to continuous quality improvement (QI) activity, with support from the highest levels of management. All Louisiana leadership are active participants on the QAPI committees which allow them an opportunity to monitor the program as well as contribute ideas. In addition, community physicians and other health care practitioners actively participate in the QI process. Following is a list of resources that supported QI Program activities:

- Quality Management Program staff including subject matter experts in the areas of QI program design, project management, accreditation, and data analysis and reporting work with the health plan on an ongoing basis to achieve program goals and objectives.
- National departments such as the national credentialing center and appeals.
- Health services including disease management, case management, pre-certification and prevention
- Utilization management including medical directors and pharmacy
- Operations
- Provider services
- Enrollment
- Compliance

- Marketing and community outreach

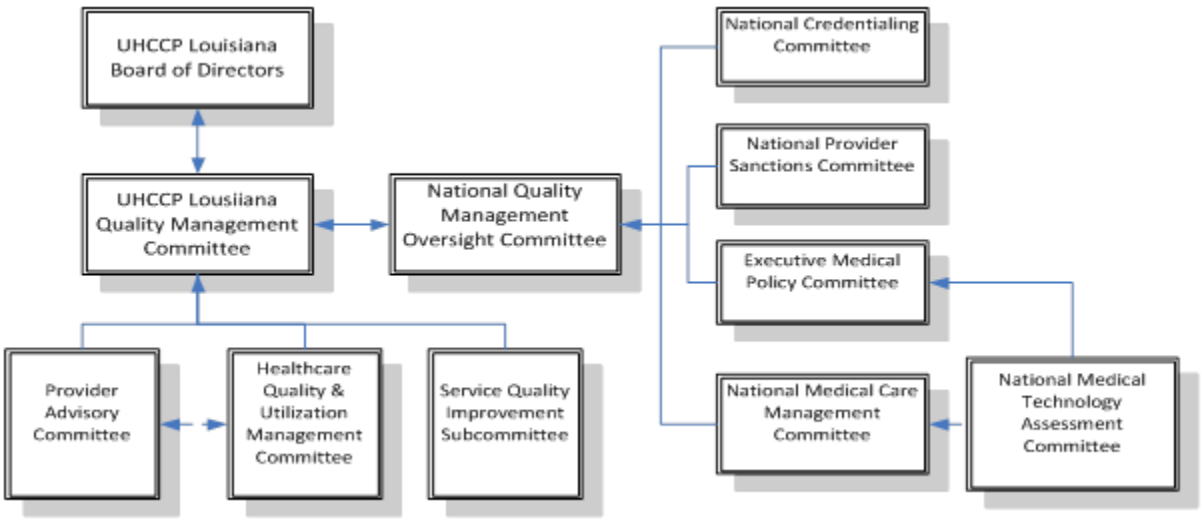
As delegated by the board of directors, Ms. Golenor and Dr. Logarbo are responsible for oversight of the QI Program and co-chair the QMC. Ms. Golenor is responsible for monitoring the quality of care and service we provide and ensuring the appropriate level of resources are available for the QI Program. Ms. Golenor also ensures that fiscal and administrative management decisions do not compromise the quality of care and service provided to members.

Dr. Logarbo is a Louisiana licensed physician and is responsible for implementation of the QI Program. She reports to Ms. Golenor and provides the medical direction for health plan staff. Dr. Logarbo:

- Chairs the Provider Advisory Committee (PAC) and the Healthcare Quality and Utilization Management Committee (HQUM), as well as co-chairs the QMC
- Participates in various QI committee activities including the credentialing and re-credentialing process and coordinates review with the PAC
- Oversees and implements activities to measure health services efficacy
- In collaboration with legal and network management, is responsible for the immediate decision and resolution of all situations involving the potential of imminent harm.

The Louisiana behavioral health medical director is a Louisiana-licensed physician who is responsible for all behavioral health activities and takes an active role in the medical management team and in clinical and policy decisions, including the QAPI program. The behavioral health medical director leads behavioral health quality improvement activities including but not limited to those related to the use of stimulants and antipsychotics, and behavioral health concerns typically treated by PCPs.

The Louisiana QAPI committee structure is shown in the diagram below. Committee membership and roles/responsibilities of each committee are listed below:



Board of Directors

The UnitedHealthcare Louisiana Board of Directors is the governing body of the organization. The Board of Director's functions, as they relate to the QI program, includes:

- Oversee QI functions
- Review and approve the QI Program Description and Work Plan, annually
- Review the Annual QI Evaluation and other reports and information as required or requested
- Provide oversight of responsibilities the Board of Directors delegates to the National Quality Management Oversight Committee (NQMOC) and the QMC.

UnitedHealthcare QAPI Committees

Quality Management Committee

The QMC is the decision-making body that is ultimately responsible for the implementation, coordination and integration of all quality improvement activities for the health plan. The responsibilities of the QMC are:

- Provide program direction and continuous oversight of QI activities as related to the unique needs of the members and providers in the areas of clinical care, service, patient safety, administrative processes, compliance, and network credentialing and re-credentialing.
- Oversee and approve the annual QI Program Description, QI Work Plan and QI Annual Evaluation. Review the Work Plan at least quarterly.
- Evaluate, at least annually, the impact and effectiveness of Medicaid specific performance improvement projects (PIPs) and recommend changes as necessary.
- Report annually or more frequently as needed, on quality activities to the Board of Directors.
- Review and accept decisions of the NQMOC that have been delegated by the Board of Directors, offering feedback as appropriate.
- Review reports and recommendations from other national and health plan QI subcommittees, act upon recommendations as appropriate and provide feedback, follow-up and direction to the committees.
- Ensure compliance with regulatory requirements and accrediting organizations.
- Provide local delegation oversight as specified by State regulatory requirements.
- Recommend appropriate resources in support of prioritized activities.
- Provide oversight of and coordination with behavioral health services.
- Maintenance of minutes of all committees and sub-committees.

The QMC membership includes:

- April Golenor, CEO (chair)
- Ann Kay Logarbo, M.D., chief medical officer (co-chair)
- Charles Freed, M.D. (interim), behavioral health medical director
- Karl Lirette, chief operating officer
- Linda Rintala, medical management manager
- Deborah Tillman, provider claims educator
- Brad Grundmeyer, member services manager
- Larry Smith, contract compliance coordinator

- Angela Olden, quality management coordinator
- Ad hoc staff as needed

The QMC meets at least four times per year and is chaired by Ms. Golenor and co-chaired by Dr. Logarbo. The QMC reports at least two times per year to the Board of Directors.

Provider Advisory Committee

The PAC performs peer review activities, including review of credentialing and review and disposition of concerns about quality of clinical care provided to members as requested by Dr. Logarbo. The PAC is responsible for evaluating and monitoring the quality, continuity, accessibility, availability, utilization and cost of the medical care rendered within the network. The responsibilities of the PAC are to:

- Provide direction for the annual QI Program Description, QI Work Plan and QI Annual Evaluation. Review the Work Plan at least quarterly.
- Monitor performance on clinical indicators (e.g., HEDIS, state metrics, PIPs, other service utilization patterns as indicated by data analysis, and continuity and coordination of medical and behavioral health care) conduct/review barrier analysis and recommend actions, as appropriate.
- Designate evaluation and study and design procedures.
- Monitor individual PCP and practice quality performance measure profiles.
- Review and accept nationally endorsed clinical practice guidelines, providing input as appropriate.
- Review summary data regarding quality of care complaints, appeals and grievances; identify trends; conduct barrier analysis and recommend corrective actions as needed.
- Review reports on mortality and inpatient quality issues, and recommend actions as indicated.
- Perform peer review of care and service issues, including recommendations for individual action plans (IAPs).
- Review of updates to the *Provider Administrative Guide* and other relevant clinical content.
- Review and accept the National Credentialing Plan, with addendum for line of business regulatory requirements as applicable.
- Perform peer review and provide oversight of final decisions by the Credentialing Committee for the credentialing and re-credentialing process.
- Monitor process for compliance with regulatory and accreditation compliance.
- Review, track and identify opportunities for improvement and make recommendations relating to medical record issues, and potential quality of care trends.
- Review provider satisfaction survey results and make recommendations for improvement.

The PAC membership includes:

- Ann Kay Logarbo, M.D., chief medical officer (chair)
- Charles Freed, M.D. (interim), behavioral health medical director
- Network primary care and subspecialty physicians*

- Quality management representatives
- Ad hoc Louisiana health plan staff as needed
- Ad hoc specialty physicians as needed

Dr. Logarbo chairs the PAC, which meets a minimum of four times per year, or more frequently as needed. Upon award of this contract, we plan to add to our PAC a non-voting DHH representative.

Members may not participate in peer review activities in which they have a direct or indirect interest in the outcome. Non-credentialing peer review must include at least one member of the involved party's specialty and must meet state regulatory requirements. Dr. Logarbo may vote in the case of a tie vote. The PAC reports to the QMC at least four times per year to ensure that findings are reported to appropriate executive authority, staff, and departments within the health plan.

** Attendance for peer review issues is restricted to network physician and health plan practitioner committee members and the quality management representatives necessary to present the issues and document recommended courses of action. Voting for peer review issues is restricted to network physician and health plan practitioner committee members. A strict conflict of interest and confidentiality policy is in force for this committee.*

Healthcare Quality and Utilization Management Committee

The HQUM monitors all clinical quality improvement and utilization management activities. The responsibilities of the HQUM are to:

- Review and accept the Utilization Management (UM) Program Description and UM Program Evaluation at least annually.
- Review and approve Care Management and Disease (Condition) Management Programs including Healthy First Steps.
- Oversee implementation of the Utilization Management Program.
- Review and approve UM performance metrics from all clinical areas, including behavioral health services. Monitor progress on clinical performance improvement programs.
- Review reports on inpatient mortality and other clinical quality issues and advise improvement actions as indicated.
- Evaluate the consistency of the UM decision-making process through inter-rater reliability reports.
- Identify over- and under-utilization issues and recommend corrective actions as indicated.
- Monitor continuity and coordination of care. Recommend improvement actions as indicated.
- Monitor medical and behavioral health coordination of care.

The HQUM membership includes:

- Ann Kay Logarbo, M.D., chief medical officer (chair)
- Charles Freed, M.D. (interim), behavioral health medical director

- Health services leadership
- Quality management representative
- Larry Smith, contract compliance coordinator
- Utilization management staff as designated by Dr. Logarbo
- Other staff members by invitation of Dr. Logarbo to lend subject matter expertise

The HQUM meets at least four times per year and is chaired by Dr. Logarbo or designee. The HQUM reports at least four times per year to the QMC. Cross reporting to the PAC is made as appropriate for peer review and other matters.

Service Quality Improvement Subcommittee

The Service Quality Improvement Subcommittee (SQIS) monitors the quality of service delivered to our members. The SQIS oversees non-clinical services and delegated functions to monitor and to support improved service to members. Responsibilities of the SQIS:

- Review member and practitioner satisfaction results and ongoing improvement activities.
- Monitor trends related to member complaint, grievance and appeal activities.
- Monitor trends related to member and provider call center activities
- Monitor access and availability results and trends.
- Review, approve and monitor member and provider service PIP and activities.
- Monitor provider service measures (e.g., claims lag, complaint resolution timeframe.)
- Review and approval of service-related operational policies and procedures.
- Review of updates to the *Provider Administrative Guide*.

The SQIS membership includes:

- Karl Lirette, chief operating officer or designee (chair)
- Member services representative
- Deborah Tillman, provider claims educator
- Quality management representative
- Claims and pharmacy representative
- Enrollment representatives as needed
- Larry Smith, contract compliance coordinator
- Other staff members by invitation to lend subject matter expertise
- Member advocate representative

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

A quorum is required for all QAPI committee meetings. If not otherwise specified in a separate Committee Charter, a majority of members (51 percent) present constitutes a quorum and all members are considered voting members. Minutes are recorded at all quality committee meetings using a standardized format including topic, discussion, recommendations and follow-up. Minute scribing is assigned by the chairperson to a committee member or other appropriate

staff, as needed. Follow-up items become topics for the next committee meeting. All minutes are maintained in a confidential manner. The chairperson reviews the minutes for accuracy and completeness. Minutes for QMC and HQUM are submitted to the State in accordance with State reporting requirements.

Current and Proposed QAPI Work Plan

The QAPI Work Plan is developed annually and updated at least quarterly with input and approval from the QAPI committee members who are the leadership team. QAPI activities involve a variety of mechanisms to measure and evaluate the total scope of services provided to health plan customers. In addition, the QI Program focused on high-volume, high-risk areas of care and service for its population. Examples of this in 2014 include: focus on health care issues that disproportionately affect African-American over other races, including breast and cervical cancer mortality, asthma management and sickle cell disease.

Performance Improvement Projects

Performance improvement projects, also known as quality improvement projects, are designed for the entire Louisiana population or a targeted population or subgroup. PIPs are studies designed to include measurement of performance, interventions, improving performance and systematic and periodic follow up on the effect of the interventions. Performance improvement indicators are objective, clearly defined, based on current clinical knowledge or health services research, and capable of measuring outcomes such as changes in health status, functional status and member satisfaction, or valid proxies of those outcomes. Interventions are evaluated and refined to achieve demonstrable improvement. Results of evaluations and recommendations are reviewed and approved at least annually by the appropriate QAPI committee described above.

Medical Record Audits

We conduct medical record review (MRR) in compliance with Section 8.2.2.9. Medical Record Reviews. In accordance with Section 8.2.3 and 8.2.4 we will conduct reviews at all PCP sites with 50 or more of our members including practice sites that have both individual offices and large group practices. We will review at least once during each 2-year period. In addition we will review at least five to 10 records at each site or three record reviews per providers of large group practices. We will share out medical record review strategy and process with DHH within 30 days of award. The objectives of the MRR are to ensure that PCPs provide high-quality health care that is documented according to established standards.

- The structural integrity of the medical record
- Documentation for the presence of information that conforms to standards of good medical practice, which includes evidence of continuity and coordination of care
- Presence of medical record confidentiality policies
- Advanced directives

The medical standards are distributed to providers. Clinical reviewers trained in the use of the MRR tools collect the data. Feedback of MRR results and areas for improvement are disseminated to physicians. Corrective actions plans are required if minimal standards not attained. Overall results and opportunities for improvement are reported to the QMC and the PAC. The results of all medical record reviews are reported to DHH quarterly with an annual summary.

Performance Measures

The monitoring of quality indicators is designed to reveal trends and performance opportunities in specific areas and facilitate improved patient outcomes and population health. To this end, a variety of care and service indicators to monitor are derived from as many sources as appropriate including HEDIS and CAHPS. The quality indicators are measurable, based on research, and use current and accepted data collection and analytical methodologies.

Topics for routine monitoring and focused activities are chosen based on the demographic and epidemiological characteristics of the population. Examples of monitoring indicators include tracking and trending of health care disparities, inpatient or outpatient acute or chronic conditions, access performance measurements, State-defined performance measures, customer and claims service, member satisfaction, or unique specific indicators as identified from local epidemiology or demographics. QI activities are designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and service provided to our members and are presented to the appropriate committee for review and recommendation.

We collaborate with state and local coalitions to further clinical quality and patient safety within the markets. These activities are reported to the QAPI committees and addressed within the QAPI Work Plan and the annual Program Evaluation.

Plan-Do-Study-Act Cycles and Continuous Quality Improvement

As part of our Quality Improvement Program, we use a variety of established tools to help support our strategic objectives and ultimately our mission to help people live healthier lives. Such tools include the Plan-Do-Study-Act cycle, Six Sigma and Rapid Cycle Improvement. These methodologies are problem-solving techniques that we apply to specific and measurable performance indicators. Quality improvement methodologies are supported by a variety of experts across the Quality Management and Performance organization, including a team of seven Six Sigma Black Belts, and regional support that includes two Certified Professionals in Healthcare Quality.

All steps in the ongoing quality improvement process, regardless of the tool used, are documented and results and action plans are presented to the appropriate committee for review and approval. One example of the quality improvement process was can be found in our work to improve member satisfaction.

- ***Define***: Upon our baseline CAHPS survey measurement, our NCQA-certified CAHPS vendor, Center for the Study of Services (CSS), conducted a key driver analysis which identifies the areas or dimensions of health plan performance that are closely related to the overall rating of the plan. The CSS Key Driver Model quantifies the contribution of each performance area to the overall rating. Our results on each performance dimension are compared to the best score among all adult Medicaid plans surveyed by CSS in 2013, yielding a measure of available room for improvement in each area. The result is then weighted by the area's contribution to the overall Rating of Health Plan score. Opportunities for improvement are prioritized based on the expected impact on the overall score resulting from improved performance in each area.
- ***Measure***: Based on the key driver analysis, the health plan conducted a barrier analysis and developed an improvement intervention strategy to address the top key areas.

Adult CAHPS 5.0H Survey Results	2013 Plan Rate	2013 UHC National Average (Medicaid)	Variance to UHC National Average	2013 NCQA Percentile
Ratings				
Rating of Personal Doctor	76.13%	79.36 percent	↓3.23%	75th

- ***Analyze:*** Analysis, limitations, barriers and interventions:

Composite/Rating Measure	Barrier	Intervention Strategy
▪ Rating of personal doctor	▪ The member is not connected to a medical home. ▪ The member does not know who his or her assigned PCP is. ▪ The member is not aware of the need to seek out preventive care	▪ Continue patient centered medical home initiatives. ▪ Engage in member engagement strategies that involve collaboration with the providers (e.g., cobranded letter and call initiatives, clinic days). ▪ Consult with the Member Advisory Council(s) to identify barriers to seeking out preventive care.

- ***Improve***: A re-measurement will be done in 2014 to evaluate effectiveness of the interventions.
- ***Control:*** Once determined how the actions taken impacted the performance upon re-measure, will seek to continue what worked, or update the intervention strategy.

Member Surveys

Member experience is assessed through member surveys and complaint data. Member experience is measured annually using the CAHPS survey and additional supplemental survey questions. Member survey data are used to:

- Measure our performance
- Establish benchmarks against national CAHPS performance data and monitor performance
- Assess the overall member experience to determine how effectively we are meeting member expectations
- Assess service performance compared to competitors

Complaint, appeal, grievance and member experience data are trended to identify potential opportunities for improvement. Actions to address opportunities for improvement are developed by the SQIS as necessary.

Provider Surveys

Physician and practice manager satisfaction surveys are designed to:

- Assess which services are important to our providers
- Determine physician and practice manager satisfaction with UM processes
- Assess satisfaction with continuity and coordination of care

Physician and practice manager satisfaction surveys are conducted annually. The survey results are summarized and reviewed by the UnitedHealthcare network team as well as SQIS to identify areas for improvement and develop action plans.

Activities that Address Health Disparities

We have made a commitment to improvements based on the needs of our changing member population. These improvements are expected to reduce health disparities by establishing the foundation for multicultural population stratification, understanding of health care needs across multicultural populations, driving/enforcing a patient-centered approach and reducing health disparities across multicultural populations. Goals include:

- Enhance the spectrum of clinical programs to meet the diverse needs of our members, understanding the needs of the multicultural markets and modify programs and materials as needed.
- Provide culturally competent member services and materials and ensure parity in access to quality care for all populations, including prenatal and postpartum care, ADHD prescribing, and other opportunities identified through data analysis or by DHH.

When analyzing results of QAPI activities we drill down to the demographic data to look for potential indicators of root causes that may be culturally of linguistically based. Data are stratified by sex, age, language, race/ethnicity, and ZIP codes, Interventions are targeted to address any disparities found.

As an example of this in 2013, we chose to focus on health care issues that disproportionately affect African-American over other races, including breast and cervical cancer mortality, asthma management and sickle cell disease. Though Louisiana ranks 40th in the United States in incidence of breast cancer, the State ranks second highest in mortality from the disease. Likewise, African-American are more likely to have asthma than their Caucasian counterparts. So we implemented targeted outreach to increase breast cancer screening, the most effective way to improve breast cancer mortality, and also tackled asthma management in initiatives ranging from provider education about treatment to engagement of schools in facilitating compliance with asthma action plans for children. In addition, we focused on identification of members with sickle cell disease and referral of those members to its case management.

Improving the Health Care Status of the Louisiana Medicaid Population

In addition to the analysis of claims and demographic data, the QAPI identifies, analyzes, and assesses the prevalence and impact of emerging trends identified as priorities by Louisiana state regulators, other organization markets, and national public health improvement partners. Targeted studies aim to investigate premature birth and childhood behavioral health care for ADD/ADHD to discover the prevalence and impact in the Louisiana Medicaid population, specific opportunities to address disparities and barriers to care, and interventions to improve outcomes.

Rationale for Selecting Particular Programs

For all quality initiatives, we objectively and systematically monitor and evaluate opportunities for PIPs aimed at improving the quality, timeliness and appropriateness of our care and service delivery. Rooted in data-based analysis, our programs are designed to provide:

- Established baselines, measure interventions and timelines for follow-up re-evaluations
- Objective, clearly defined indicators based upon current clinical knowledge or health services research
- Intervention outcomes (e.g., changes in health status, functional status and member satisfaction) or valid proxies of those outcomes
- Identifiable clinical improvement opportunities based on the needs of the population, collaborative opportunities with our state partners, or feedback from our participating physicians
- Structured processes and scientific methodology set by the accrediting entity, regulatory agency or designated EQRO

In addition to State required PIPs, the QMC or other quality improvement subcommittees may develop, maintain and approve other PIPs as informed by data analysis. We also may reach out via the PAC to solicit network provider input on the development of clinical interventions for PIP initiatives.

We will support joint performance improvement projects involving the health plan, and our competitor MCO(s), as appropriate.

Process Used to Select Performance Improvement Projects

We continually endeavor to find areas of our operations to modify so that we can improve the quality of services provided to members and providers. We identify and establish PIPs to improve our program performance. Our quality committee continuously evaluates, discusses and approves PIP-related progress reports. We follow an eight-step methodology for identifying and designing a PIP:

1. ***Data Collection:*** Data are collected and analyzed that measures member health outcomes and satisfaction with health plan services. We review HEDIS data, utilization data, care management and disease management data, member survey results and member grievance data. Member grievance data are categorized by quality of care issues, member access, attitude and service, billing and financial issues, and quality of practitioner office sites. Topics are selected by the State or are based upon the prevalence of the issue within the membership, the importance or risk of the issue to the membership, and reported rates versus established benchmarks.
2. ***Review and Approval:*** Projects are presented to the applicable quality committee for input and approval. The project is presented to DHH for approval.
3. ***Setting Benchmarks***: We establish quantifiable indicators which clearly and accurately measure the activity being evaluated. Indicators measure changes in health or functional status or member satisfaction. Baseline benchmarks and goals are set along with information on how the benchmarks and goals were derived. In addition, process measures are established and evaluated as applicable to verify that interventions are being implemented and progressing as planned.

4. ***Development:*** After conducting an initial analysis, the QMC develops and implements an intervention(s) that has a high chance of success. Interventions are selected that are known to be effective and suitable to the population selected. The timing and course of interventions must also be determined in addition to:
   - The date the intervention begins
   - The number and percent of the population who actually received the intervention
   - Whether the intervention was conducted as expected or if issues arose which interfered with the implementation
5. ***Analysis:*** A quantitative analysis is conducted to determine if:
   - The rate changed over the original measurement selected
   - Goals/benchmarks have been met
   - As rate change is evident, statistical significance or linkage to the timing of the intervention
   - Interventions should continue or if changes are needed. These are based upon additional quantitative and qualitative analysis. If QI actions were successful; the new processes are standardized and monitored. If the actions were unsuccessful, the QMC will determine and implement changes to the current interventions.
6. ***Re-measurement:*** The QMC reviews re-measurement to determine if improvements have been sustained or if new interventions have resulted in improvement. When sustained improvements have been demonstrated, projects may be discontinued. A 3-year cycle is common but projects may be shorter to take advantage of rapid cycle improvement techniques or may be longer if the topic, design or results indicate that to be advantageous to meeting the quality improvement goals set.
7. ***Monitoring:*** Interventions that resulted in sustained improvement are standardized and monitored. Final project reports and recommendations for termination are presented before the applicable health plan quality committee for approval prior to project discontinuance. If it is a State-mandated project, DHH determines when it can be discontinued.
8. ***Reporting:*** PIPs including project outcomes are reported on the form as specified in the DHH's MCO Quality Companion Guide. Pursuant to Sections 14.2.8. Performance Improvement Projects and 14.2.9. Performance Improvement Projects Reporting Requirements, the forms are updated and presented to the QMC for approval, and then to DHH for review and comment on at least an annual basis. In addition, we shall submit project data analysis monthly.

Keeping DHH Informed of QAPI Program Actions

We appreciate the strong and collaborative relationship we have with DHH and look forward to continuing our partnership. Through our regular formal and informal meetings as well as through submission of reports, we will continue to keep DHH apprised of our QI Program and initiatives.

Communication of QI Program activities is accomplished through various mechanisms, including but not limited to:

- Board of Director and quality committee reports
- Member and practitioner newsletters and Internet portals

- Member and practitioner handbooks
- Regulatory body reports and surveys
- Staff meetings, employee communication materials and intranet portals

Innovative Programs for Members

We are working on several innovative programs to improve our ability to eliminate gaps in care for members and to provide administrative simplification for providers.

Supporting Vietnamese-language Members

We are proposing a new interactive voice response program that will support the State's Louisiana Vietnamese which are estimated at 25,000 individuals, the majority living in the New Orleans area. For these members, we will build out the capability of our current member services greeting to provide members with an option for Vietnamese-language in addition to English or Spanish language options. We will collaborate with DHH on a call script and translate it into Vietnamese for recording by a native speaker.

Sickle Cell Chronic Disease Management

Sickle Cell Outreach program identified Louisiana members with sickle cell disease and provided trained nurses to conduct outreach phone calls. The purpose of the outreach was to provide education and engage the member with a PCP and provider experienced in treating sickle cell disease or a specialist that can work with the member to properly manage their condition. We completed the outreach June 1, 2014. We contacted 366 members and reached and educated 141 members (39%). 50 members received written education and 20 members asked to speak with a case manager and were referred to case management.

We are proposing a member outreach campaign to provide resources to help members live with sickle cell disease (SCD), a condition that creates a significant health disparity for African-American and Hispanics. Louisiana has a high incidence of sickle cell disease statewide. SCD-related diagnoses are a top five cause of ER visits and inpatient admissions and a trigger for pain management needs.

Our national clinical team has significant experience managing the care of members with SCD, and therefore they understand the unique needs of these members. We have leveraged this team's expertise to develop a SCD program that enhances our person-centered clinical model by offering timely SCD-specific interventions and resources, which are tailored to individual member needs. Our SCD program addresses the challenges unique to each stage of life—from newborn through adulthood—to mitigate disease progression and complications and improve the quality of life for members with SCD. Our SCD expertise includes:

- Associate medical director Dr. Lanetta Jordan, a world-renowned expert in SCD, helped develop our SCD program. She participated in the development of national SCD evidence-based guidelines sponsored by the National Institutes of Health (NIH).
- Our national clinical team has a combination of Medicaid experience and hands-on experience managing members with SCD.
- Sickle cell disease medical director Dr. Paul Monte is American Board of Internal Medicine-certified and has significant experience managing patients with SCD in a hospital setting. Dr. Monte will oversee our national SCD program.

- National SCD expert panel, comprising board-certified experts in treating members with SCD, reviews and updates all clinical components of our program under the oversight of Dr. Monte.

Our national clinical quality team is adopting SCD evidence-based guidelines tailored to the needs of Louisiana members, based upon the NIH guidelines (e.g., clinical trials or managing transplants for members with SCD). The team has also developed a pain management process to help SCD members manage their daily pain levels so they are not visiting the ER or admitting themselves into the hospital.

Sickle Cell Health Outreach Efforts

As a result of this customized health outreach campaign, we are taking the following actions that work to eliminate health disparities through a significant effort to provide expert consultation, provider education and member engagement in improved health care outcomes.

- Identifying gaps in our provider network so that we can develop an interconnected network of physicians who are experienced in treating SCD.
- Identifying educational opportunities for PCPs, which includes information on how to manage members with SCD (e.g., use of Hydroxyurea, penicillin and Transcranial Doppler [TCD] screening). PCP education is critical to providing PCPs the knowledge they need to successfully manage the care of members with SCD. For example, TCD screening is a covered benefit that screens for the risk of a stroke. The results of the screening allow the provider to conduct interventions, such as regular blood transfusions, to minimize stroke risk.
- Developing a Louisiana-specific advisory panel that will be made up of non-clinical members, such as community organizations and caregivers, to understand the unique needs of Bayou Health members.
- Working to establish an SCD Center of Excellence in Louisiana, consisting of local providers and specialists with expertise managing members with SCD. This center of excellence will work to improve the care and management of Bayou Health members with SCD.

Ongoing sickle cell program interventions include:

- Ongoing evaluation and risk stratification
- Creating, updating, communicating and managing a person-centered plan of care
- Periodic member assessment
- Monitoring and managing ER and inpatient admissions and readmissions
- Coordinating access to appropriate support services both inside and outside of the system
- Member, caregiver, physician education
- Member advocacy throughout all stages of the care continuum

Once implemented in Louisiana, our SCD program will enhance our person-centered model of care by:

- Identifying members with SCD who are at risk for ER use and inpatient admissions (e.g., members experiencing recurring pain crises). We identify members through:
  - Analysis of claims and clinical data and risk stratification using Impact Pro.

  - The new-member welcome call and HRA. For members identified with SCD through the HRA, we refer them to our SCD clinical team for a comprehensive sickle cell assessment to identify member needs and their risk level.
- Engaging high-risk members in case management through collaboration between the members' PCP and a case manager with expertise in managing members with SCD or enrollment in an Accountable Care Community (ACC) practice with SCD expertise. For ACC practices without this expertise, our SCD case manager will partner with the Accountable Care Community practice to manage the member's care.
- Implementing a "feet-on-the-street" model to increase member engagement. Our SCD case manager and community health workers will conduct member engagement-related activities. Partnerships with community-based organizations that support SCD members will help to increase member engagement.
- Engaging providers and members at clinics, hospitals, schools and community events to provide education, develop relationships and connect members to community resources.
- Implementing local, field-based SCD experts, supported by telephonic experts who help find members, conduct the sickle cell assessment, identify gaps in care and resolve barriers to care, such as transportation).
- Coordinating with behavioral, pharmacy and other services, such as Healthy First Steps.
- Ensuring development of an effective, person-centered plan of care to reduce pain and manage symptoms, including short and long-term goals.
- Ensuring members have a pain management plan to manage their daily pain levels so they are not visiting the ER or admitting themselves into the hospital.
- Providing member/caregiver education and support, such as use of Hydroxyurea; managing daily life functioning; coping with cognitive functioning issues; understanding how to speak with providers; transitioning to adult condition management, including managing their own care; and empowering members to get what they need to manage their condition from their provider.

Early and Periodic Screening, Diagnostic and Treatment Program

We provide comprehensive preventive health benefits to our members from birth to age 21. The EPSDT program includes administrative and direct services. The administrative services include a variety of member/provider outreach and follow-up activities. Direct services offer comprehensive preventive health care screenings through contracted providers.

We conduct outreach to members and practitioners as part of its EPSDT program. This outreach is provided through multiple avenues including written education related to the components of a comprehensive screening exam and the periodicity schedule and reporting to the practitioner on his assigned members in need of services.

Our EPSDT program also includes collaboration with other UnitedHealthcare health plans. Through these partnerships, multiple resources are linked to enhance member and provider educational efforts. These resources are also be used to coordinate services and/or to identify additional means of contact for hard-to-reach members.

Using state and/or national guidelines, quality indicators for preventive care services are monitored and evaluated on a continual basis and interventions are implemented as indicated for continued quality improvement.

Preventive Care Program

The Preventive Care Program is an outreach program serving our members. We provide preventive health and screening services for our members within our program benefits. Because of the demographics of the enrolled population, targeting these groups for preventive services has the potential to yield improvements for a large number of members.

We choose preventive service indicators that reflect important aspects of care for our members -- indicators that are relevant to the enrolled population, are reflective of high-volume services, encompass preventive and chronic care, and span a variety of delivery settings. Categories of indicators include the following:

- Preventive (e.g., EPSDT, lead screening, immunizations, cervical cancer screening, breast cancer screening, chlamydia, syphilis screening in pregnant women, use of long-acting reversible contraceptives and HIV screening, and well child visits)
- Chronic care (e.g., diabetes, cholesterol management, treatment of asthma)
- Access/availability of care

Preventive services are both population and condition based. Using multiple data sources, including but not limited to HEDIS and claims data, members are identified for outreach. Claims/encounter data are monitored on an ongoing basis to identify members in need of services and to provide feedback to practitioners on individual performance as well as our overall performance.

Outreach is provided in both written and verbal form. On a routine basis, mailings are sent to members to provide education related to preventive care and/or screenings due. Verbal outreach is provided through both automated telephone calls and direct-member outreach. In addition, on an annual basis, written information is mailed to members to encourage the utilization of physical exams and recommended screenings. Educational information related to preventive care is also made available to members on our website, *myuhc.com*. Communication with internal departments including case management, member services and provider services is ongoing to promote the Preventive Care program and to work collaboratively on individual cases when indicated.

Educational and member-specific information is submitted to practitioners on a routine basis to provide up-to-date screening guidelines and notification of screenings due among the assigned member panel. On-site visits to practitioners may also be conducted for focused education and/or medical record review.

We develop partnerships with community and state agencies for health promotion on a communitywide scale. Through these partnerships, multiple resources are linked to enhance member and provider educational efforts. These resources are also used to coordinate services and/or to identify additional means of contact for hard-to-reach members.

Using state and/or national guidelines, as well as HEDIS data, quality indicators for preventive care services are monitored and evaluated on a continual basis, and interventions are implemented as indicated for continued quality improvement.

Patient Safety

We are committed to patient safety which is demonstrated through the programs available to support our members. Additionally, we support industry standards that reduce preventable medical errors and improve patient safety. The objectives of the Patient Safety Program are to:

- Increase collaboration in transparent quality and efficiency outcome reporting with external entities including The Leapfrog Group and NCQA.
- Advance appropriate care, best practices and patient safety based on fact and scientific evidence.
- Educate members on the importance of patient safety in the continuum of care; and provide members and physicians with updated and accurate patient safety information.

Core Patient Safety activities are a collaboration of initiatives across many areas that include but are not limited to pharmacy, care management, network providers and health care delivery. We perform Specific Patient Safety initiatives, such as the misuse and abuse drug monitoring program and quality of care and service issue.

Innovative Programs for Providers

BayouCloud

UnitedHealthcare is transitioning from our traditional Web portals to applications hosted within our cloud portal. We are starting with the administrative functions that providers commonly need. The cloud provides a central access point for the suite of UnitedHealthcare websites and applications, many with the simplicity of single sign-on security. This tool will enable all providers to report their EPSDT visit and referral information in a hosted interactive Web form that records services members received.

New features and functions can and will be added to BayouCloud that will streamline processes and reduce administrative burdens on providers. Cost savings are achieved through greater use of self-service capabilities for providers and reduction of common work tasks historically requiring internal manual effort. This cloud-based real-time solution is the cornerstone of our goal to provide a single provider platform to bring together multiple websites and both administrative and clinical applications to simplify transactions. With access to the BayouCloud 24 hours a day, seven days a week, provider offices conduct business with UnitedHealthcare when it is convenient for them.

As we deploy this advanced technology solution, we are ready and willing to offer this infrastructure and expertise for any or all of its data solution components to the State and to other MCOs to enable and facilitate data sharing. For example, to help address EPSDT data collection and reporting across the state and across the awarded MCOs, at DHH's discretion and in cooperation with the other MCOs, we propose to create and host in our cloud infrastructure a new common repository and Web application. **This tool will enable all providers to report their EPSDT visit and referral information in a hosted interactive Web form that records services members received.** This information will then be available for all MCOs to report and conduct referral follow ups.

Provider Profiling

Annual PCP utilization and quality profiles are designed by the national quality management department. Profiles summarize utilization history on five utilization and nine quality indicators for PCPs with sufficient data to generate statistically significant profiles. Individual provider scores are compared to network peer scores.

The utilization indicators include encounters and visits to ER and hospitals. Quality indicators include visits by age range for children, immunizations by age range, and screenings for cervical and breast cancer screening.

To identify potential over-utilization or under-utilization, profile data are further analyzed to identify scores greater than one standard deviation from the mean. Providers in the lowest quartile are targeted for quality improvement initiatives.

An annual evaluation is done by considering all aspects of the QAPI and analyzing overall effectiveness and progress toward goals. Identified barriers and selected opportunities for improvement for each area of clinical care and service described in the evaluation will be specifically addressed through actions in the 2015 QAPI Work Plan.

Partnerships with Non-Traditional Health Care Settings

Strategy for Collaboration with School-Based Health Centers

To date, we have engaged successfully with Health Centers in Schools (HCS), the organization that supports school-based health clinics (SBHCs) in East Baton Rouge Parish. Quality management and performance (QMP) and the marketing and community outreach team collaborated with HCS to conduct a health fair at Broadmoor High School in February 2014. Over 350 students attended the fair during their physical education classes throughout the day.

UnitedHealthcare and HCS together promoted the importance of adolescent well-child visits and screenings for sexually transmitted infections, including chlamydia. Other participants at the fair included Pennington Research Center, institutions offering educational programs for careers in health care, and Trader Joe's who provided healthy snacks for the students. Pennington is currently conducting research on motivation to participate in physical activity. They demonstrated activities from their Klub Kinnect program, which uses X-Box games to engage girls in physical activity.

Dr. Logarbo is in regular contact with Sue Catchings at HCS who is a long-term major player in the Louisiana SBHC space. The PCP promotion specialist is also regularly engaged with the SBHCs.

In April 2014, UnitedHealthcare was a sponsor for the annual Louisiana School-Based Health Alliance conference. In addition, the QMP director spoke on SBHC collaboration with the Bayou Health plans at the conference. Going forward, relationships with the SBHCs will be leveraged to support member retention, growth and quality improvement as follows:

- Ensure accuracy of reports available in the Universal Tracking Database
- Leverage the successful QMP Clinical Practice Consultant (CPC) program to provide regular “opportunities for care” reports to contracted SBHCs once the accuracy of the reports is verified

- Leverage the CPCs, provider advocates and the PCP promotion specialist to identify contracting opportunities in the SBHCs
- Contract with 12-month SBHCs
- Continue the existing local quality outreach coordinator program to conduct clinic days and/or health fairs at SBHCs.
- Continue community engagement in conjunction with the SBHCs (e.g., the Louisiana School Based Health Alliance conference).

We are committed to achieving the goals and objectives set forth in the QAPI and from DHH, and to effectively and efficiently using resources. Our QI staff will continue to work with divisions throughout the health plan, QMP, UnitedHealth Group and DHH. We believe this integration of subject matter expertise and data-driven processes from both clinical and operational teams will promote continued improvement in the quality of care and service for our Bayou Health members.

U.5 Describe the process that will be utilized to develop the performance improvement projects (PIPs) identified in Appendix DD of the RFP. Include a preliminary plan for at least one (1) required PIP including the following:

- The study question;
- The study population;
- The quantifiable measures to be used;
- Baseline methodology;
- Data sources;
- Data collection methodology and plan;
- Data collection plan and cycle; (20 points)

In compliance with Section 14.2.8.2, we will perform a minimum of two DHH-approved PIPs in each contract year, the required 3-year PIP (Appendix DD), as well as a 1-year PIP (Appendix DD, Section 2).

Approach to Identifying QI Activities

For all other PIPs that are not required by the State, we objectively and systematically monitor and evaluate opportunities for PIPs aimed at improving the quality, timeliness and appropriateness of our care and service delivery. Rooted in data-based analysis, our PIPs are designed to provide:

- Established baselines, measure interventions and timelines for follow-up re-evaluations
- Objective, clearly defined indicators based upon current clinical knowledge or health services research
- Intervention outcomes (e.g., changes in health status, functional status and member satisfaction) or valid proxies of those outcomes
- Identifiable clinical improvement opportunities based up regulatory or accreditation requirements
- Structured processes and scientific methodology set by the accrediting entity, regulatory agency or designated EQRO

In addition to State required PIPs, the QMC or other quality improvement subcommittees may develop, maintain and approve other PIPs as informed by data analysis. We also may reach out via the PAC to solicit network provider input on the development of clinical interventions for PIP initiatives.

We will support joint performance improvement projects involving the health plan and our competitor MCO(s), as appropriate.

Process Used to Select Performance Improvement Projects

We continually endeavor to find areas of our operations that can modified so that we can improve the quality of services provided to members and providers. We identify and establish performance improvement projects to improve our program performance. Our QMC continuously evaluates, discusses and approves PIP-related progress reports. We follow an eight-step methodology for identifying and designing a PIP:

1. ***Data Collection:*** Data are collected and analyzed that measures member health outcomes and satisfaction with health plan services. We review HEDIS data, utilization data, care management and disease management data, member survey results and member grievance data. Member grievance data are categorized by quality of care issues, member access, attitude and service, billing and financial issues and quality of practitioner office sites. Topics are selected by the State or are based upon the prevalence of the issue within the membership, the importance/risk of the issue to the membership, and reported rates versus established benchmarks.
2. ***Review and Approval:*** Projects are presented to the applicable quality committee for input and approval. The project is presented to DHH for approval.
3. ***Setting Benchmarks***: We establish quantifiable indicators which clearly and accurately measure the activity being evaluated. Indicators measure changes in health or functional status or member satisfaction. Baseline benchmarks and goals are set along with information on how the benchmarks and goals were derived. In addition, process measures are established and evaluated as applicable to verify that interventions are being implemented and progressing as planned.
4. ***Development:*** After conducting an initial analysis, the QMC develops and implements an intervention(s) that has a high chance of success. Interventions are selected that are known to be effective and suitable to the population selected. The timing and course of interventions must also be determined in addition to:
   - The date the intervention begins
   - The number and percent of the population who actually received the intervention
   - Whether the intervention was conducted as expected or if issues arose which interfered with the implementation
5. ***Analysis:*** A quantitative analysis is conducted to determine if:
   - If the rate changed over the original measurement selected
   - If goals/benchmarks have been met
   - If a rate change is evident, statistical significance or linkage to the timing of the intervention

- If interventions should continue or if changes are needed. These are based upon additional quantitative and qualitative analysis. If QI actions were successful, the new processes are standardized and monitored. If the actions were unsuccessful, the QMC will determine and implement changes to the current interventions.

6. ***Re-measurement:*** The QMC reviews re-measurement to determine if improvements have been sustained or if new interventions have resulted in improvement. When sustained improvements have been demonstrated, projects may be discontinued. A 3-year cycle is common but projects may be shorter to take advantage of rapid cycle improvement techniques or may be longer if the topic, design or results indicate that to be advantageous to meeting the quality improvement goals set.
7. ***Monitoring:*** Interventions that resulted in sustained improvement are standardized and monitored. Final project reports and recommendations for termination are presented before the applicable health plan quality committee for approval prior to project discontinuance. If it is a State-mandated project, DHH determine when it can be discontinued.
8. ***Reporting:*** PIPs including project outcomes are reported on the form as specified in the DHH's MCO Quality Companion Guide. Pursuant to Sections 14.2.8. Performance Improvement Projects and 14.2.9. Performance Improvement Projects Reporting Requirements, the forms are updated and presented to the Quality Management Committee for approval, and then to DHH for review and comment on at least an annual basis. In addition, we shall submit project data analysis monthly.

Preliminary Plan for Required PIP

The goal of a quality program, including the adherence to quality indicators and measures, is to facilitate improvement in care and services to our members. One of the issues that we have chosen to focus our improvement efforts on in Louisiana is the issue of premature birth reduction.

Premature birth is defined as a birth that takes place between 20 and 37 weeks of gestation,[1] or in other words, a birth that occurs more than three weeks prior to the baby's due date.[2] Over 12 percent of all babies born in the United States are born prematurely; in the non-Hispanic black population the rate exceeds 16 percent.[3] Premature births come with a staggering cost, with a conservative societal economic impact estimate of over $26 billion in the U.S in 2006.[4] These costs are related to medical care for complications of premature birth for infants and mothers, early intervention services and special education services. Furthermore, as indicated in the graph below, a disparity in the number of preterm births by maternal race/ethnicity also exists.

In recognition of the impact of the issue, the state of Louisiana through its contract with UnitedHealthcare requires that we design and implement a 3-year PIP to address the premature birth rate among Medicaid recipients.

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1 American Congress of Obstetricians and Gynecologists. Available online at: www.acog.org (August 20, 2014)

2 Mayo Clinic. Available online at: www.mayoclinic.org (August 20, 2014)

3 Center for Disease Control, National Prematurity Awareness Month. Available online at: http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregcomplications.htm (August 20, 2014)

4 Preterm Birth: Causes, Consequences, and Prevention. Available online at: http://www.ncbi.nlm.nih.gov/books/NBK11358/ (August 20, 2014)

Our QMC will formally approve a focus on reducing premature birth rates in Q1 2015.

PIP Selection Rationale

Like the United States as a whole, the premature birth rate is a public health issue in Louisiana. Louisiana has one of the highest premature birth rates in the nation. In 2012, one in seven babies (15.3 percent of live births) was born premature in Louisiana. Among non-Hispanic blacks, the rate is almost one in five (19.8 percent).[5] This PIP looks to reduce disparities related to geography and health factors.

We estimate that our member population will deliver approximately 13,000 babies in 2014. Using the 2012 prematurity rate of 15.3 percent to estimate, the potential opportunity for impact is 2,000 deliveries per year. The improvement of birth outcomes and prevention of even one prolonged NICU stay has a significant financial impact, not to mention the emotional consequences and physical risk to the newborn and its parents.

The Study Question

Is administration of antenatal progesterone effective in reducing premature births?

This study is designed to reduce premature births as defined by the March of Dimes. The population includes all pregnant women enrolled in UnitedHealthcare, with denominator exclusions as defined in the March of Dimes specifications. If the State later provides a different specification, the State specification shall supersede the March of Dime's definition.

The State-specified goal for the study is to reduce the prematurity rate by 15 percent by the end of the 3-year contract period. This would result in a goal rate of 12.8 percent for UnitedHealthcare (85 percent x 15.3 percent), and will be formally adopted at the health plan's QMC meeting to be held in Q1 2015.

The Study Population

All pregnant women enrolled in UnitedHealthcare Community Plan of Louisiana

As mentioned above, in recognition of the impact of the issue, the state of Louisiana through its contract with UnitedHealthcare requires that we design and implement a 3-year PIP to address the premature birth rate among Medicaid recipients. Our QMC will formally approve a focus on reducing premature birth rates in Q1 2015. The population includes all pregnant women enrolled in UnitedHealthcare, with denominator exclusions as defined in the March of Dimes specifications. If the State later provides a different specification, the State specification will supersede the March of Dime's definition.

5 March of Dimes Peristats for Louisiana. Available at: http://www.marchofdimes.com/Peristats/ViewTopic.aspx?reg=22&top=3&lev=0&slev=4 (August 20, 2014)

Quantifiable Measures to be used

Use of Performance Indicator Populations

Performance Indicator 1: Percentage of pregnant women with premature singleton deliveries

- Numerator: Number of premature live singleton deliveries
- Denominator: Number of live singleton deliveries

Performance Indicator 2: Percentage of pregnant women given antenatal progesterone

- Numerator**: Number of pregnant women with live singleton deliveries given antenatal progesterone
- Denominator**: Number of pregnant women with live singleton deliveries

*** Will change to the DHH/ULM specification of the antenatal progesterone measure in Appendix J when known*

Baseline Methodology

Our Approach

- ***Performance Indicator 1:*** Consistent with the American College of Obstetricians and Gynecologists definition a premature birth is defined as a baby born between 20 weeks 0 days and 36 weeks 6 days of gestation. For monthly monitoring gestational age will be retrieved from claims. For annual PIP reporting the health plan will corroborate its calculated rate with State Vital Records data if available.
- ***Performance Indicator 2:*** Administration of antenatal steroids progesterone will be retrieved from claims using the HCPCS and CPT codes as specified in the UnitedHealthcare Drug Policy on 17-alpha-hydroxyprogesterone caproate in effect as of February 1, 2015. Specific codes will be added to this PIP document once appropriate approvals are obtained.

Data Sources

Guidelines

- ***Performance Indicator 1:*** (Gynecologists definition) A premature birth is defined as a baby born between 20 weeks 0 days and 36 weeks 6 days of gestation. For monthly monitoring, gestational age will be retrieved from **claims**. For annual PIP reporting, the health plan will corroborate its calculated rate with State Vital Records data if available.
- ***Performance Indicator 2:*** Administration of antenatal steroids progesterone will be retrieved from **claims** using the HCPCS and CPT codes as specified in the UnitedHealthcare Drug Policy on 17-alpha-hydroxyprogesterone caproate in effect as of February 1, 2015. Specific codes will be added to this PIP document once appropriate approvals are obtained.

Data Collection Methodology and Plan

Guidelines

- ***Performance Indicator 1:*** Consistent with the American College of Obstetricians and Gynecologists definition, a premature birth is defined as a baby born between 20 weeks 0 days and 36 weeks 6 days of gestation. For monthly monitoring, gestational age will be retrieved from claims. For annual PIP reporting, the health plan will corroborate its calculated rate with State Vital Records data if available.
- ***Performance Indicator 2:*** Administration of antenatal steroids progesterone will be retrieved from claims using the HCPCS and CPT codes as specified in the UnitedHealthcare Drug Policy on 17-alpha-hydroxyprogesterone caproate in effect as of February 1, 2015. Specific codes will be added to this PIP document once appropriate approvals are obtained.

Data Collection Plan and Cycle

Data collection periods are defined as follows:	
Baseline	January 1 – December 31, 2014
Re-measurement period 1	January 1 – December 31, 2015
Re-measurement period 2	January 1 – December 31, 2016
Re-measurement period 3	January 1 – December 31, 2017

Project Timeline

Event	Timeframe
Submission of Project Proposal	Three months after execution of the Contract
Baseline Measurement Period	January 1 – December 31, 2014
Interim Measurement Period	January 1 – December 31, 2015
Interim Measurement Period	January 1 – December 31, 2016
Final Measurement Period	January 1 – December 31, 2017
Submission of Final Report	TBD, 2018

Interventions/Changes for Improvement

Interventions will be targeted to the study aim and should be reasonable and practical to implement considering plan population and resources.

Intervention Recommendations

- Interventions A – B delineated in Table 1 below will be discussed at the HQUM subcommittee held in Q1 2015, with recommendations to be reviewed, discussed, and approved at the Q1 2015 QMC meeting.
- Interventions A – B will be approved to address the barriers identified.

	Table 1. Planned Interventions and Barriers Addressed	Barrier(s) Addressed (see figure)
A	Reform reimbursement for antenatal progesterone	
B	Develop provider education materials and dissemination plan for antenatal progesterone clinical practice guidelines and coding for obstetricians	

Barrier Analyses

Barrier analysis will be conducted at the Healthcare Quality and Utilization Management subcommittee held in the Q1 2015 with recommendations reviewed and discussed at the Quality Management Committee held in the Q1 2015. Barriers will be summarized in a fishbone diagram using the template diagram presented in the figure below.

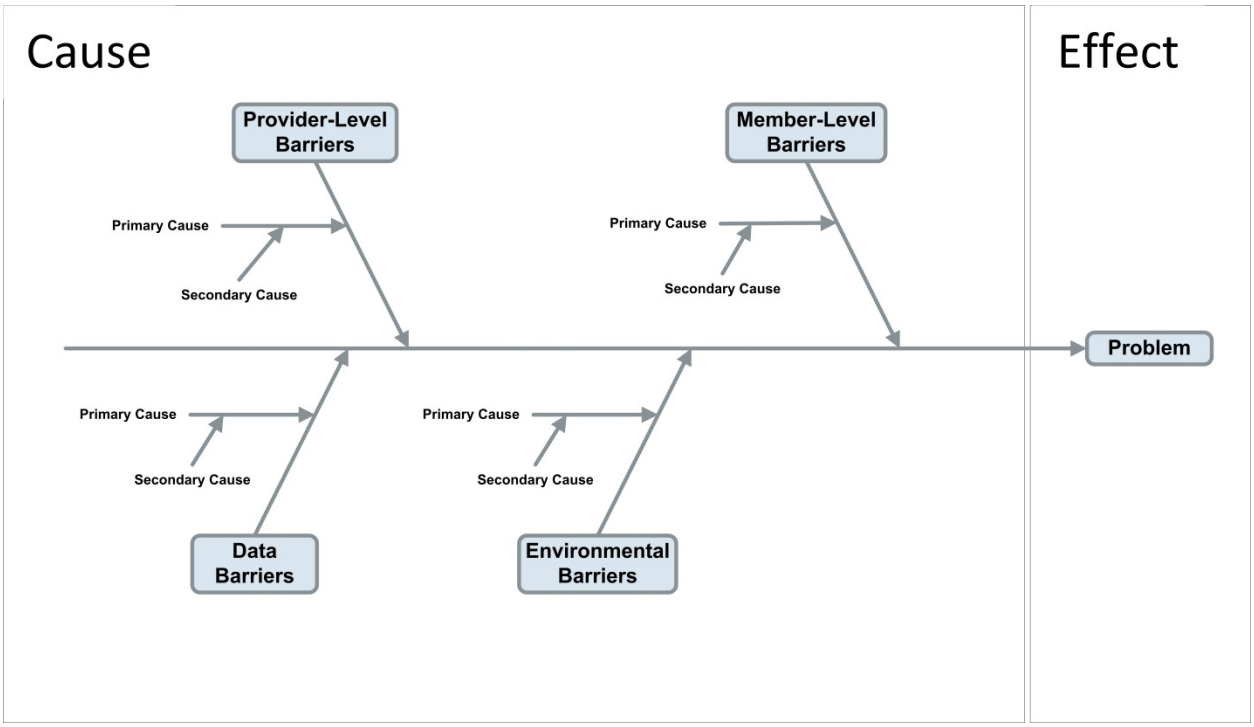

Figure 52. Barrier Analysis fishbone diagram

Results

Project Findings						
The results section should quantify project findings related to each study question and project indicators. Do not interpret the results in this section.						
Measure	**Baseline Rate 2014**	**2015**	**2016**	**2017**	**Goal**	**Goal Met?**
1: Prematurity Rate					12.8%	
2: Antenatal Progesterone					5.0%	

Discussion

The discussion section is for explanation and interpretation of the results.

Next Steps

In this final section, discuss ideas for taking your project experience and findings to the next step.

- Calculate baseline measures for 2014 where data are available
- Conduct formal barrier analysis and approve interventions

- Implement procedures for data capture where data gaps exist
- Implement approved interventions
- Calculate performance measures
- Track and monitor
- Assess performance and revise interventions.

Part VIII: Program Integrity

Section V: Program Integrity

V.1 Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Include other best practices, you have utilized in other contracts that could be to utilized in this contract. (50 points)

We are committed to providing Bayou Health members with access to high-quality medical care while protecting the ethical and fiscal integrity of the Bayou Health program. We will comply with the program integrity requirements in accordance with Section 15 by operating a Fraud, Waste and Abuse (FWA) program that includes: prevention, detection, reporting, corrective action and best practices.

Our use of sophisticated technology is supported by a Louisiana-based team led by our program integrity officer Larry Smith. Our FWA, program integrity and compliance process offers DHH:

Local Presence

- Locally based investigative team led by Mr. Smith who will build upon the current FWA Program and bring additional tools and programs to the State to combat FWA and ensure the integrity of the claims we will pay.
- Participation in regularly scheduled meetings with the Louisiana program integrity/Medicaid Fraud Control Unit (MFCU)

National Experience

- Leveraging national resources through our payment integrity division and state-of-the art tools, resources and data analytics from our services and technology division, Optum, in the provision of program integrity services
- Delivering more than $3 billion in annual savings nationally using a dedicated program integrity workforce
- Medicaid program integrity expertise based upon 12 Medicaid fee-for-service (FFS) programs and 26 Medicaid managed care programs

Proven Technology and Processes

- Customized analytic solutions developed to use a mixture of descriptive analytics, predictive modeling, data mining, machine learning, forecasting, optimization, simulation and experimental design
- Comprehensive policies, procedures and work plans
- Extensive education and training for both employees and providers

Approach for Meeting Program Integrity Requirements

Our approach for meeting the program integrity requirements, following Section 15 of the contract, includes having FWA staff on the ground in Louisiana who know the market, know the providers, interact with law enforcement, as well as other MCO program integrity staff who support those local resources with tools, technology and national expertise. Leveraging best practices established from our Medicaid programs in 23 states, we will deploy best in class processes and apply our extensive knowledge gained from partnering with other state MFCUs to combat FWA.

By using the state-of-the art tools, resources and data analytics, DHH will benefit from the full spectrum of services that include:

- A national perspective gained from processing more than 1 million claims per day – and a vast health care claims and fraud case data from nearly 100 million covered lives
- A knowledge library with more than 1,200 standard data algorithms – encompassing 9 million industry rule combinations, regulations and medical policy standards
- Extensive clinical knowledge from more than 800 anti-fraud professionals, including physicians, nurses, Ph.D. statisticians and certified professional coders

Our program results nationally include more than $3 billion in savings delivered annually using a dedicated program integrity workforce. Our end-to-end process focuses on prospective and retrospective detection, investigation and recovery for a holistic approach to program integrity comprising the following elements:

- Detection methodologies and analytics to determine if provider payments are made for the correct amount for covered services actually provided
- Eligibility determination
- Provider screening to assure that providers meet state and federal participation standards
- Claims payment and review processes to assure federal and state-specific payment and policy requirements are accounted for within the claims payment and review process
- Coordination of benefit services to assure that the Medicaid plan is the payer of last resort

Our combined prepay solution (before we pay claims) and retrospective solution (after we pay claims) coupled with our advanced Medicaid-tuned analytics and technology infrastructure has resulted in reduced provider abrasion, maximizing access to care while simultaneously achieving cost savings for our Medicaid customers.

Our solution deploys one of the broadest analytics inventories on the market, addressing virtually all health service categories including inpatient, professional, outpatient, transportation, durable medical equipment (DME), lab/X-ray, pharmacy, long-term care services, home and community-based services (HCBS) and hospice. This expansive reach allows both DHH and UnitedHealthcare to effectively monitor virtually the entire program.

Medicaid Program Integrity Initiatives Save States Millions

State of Iowa.

The state of Iowa contracted with Optum for the entire administration of the program integrity functions in 2010. We apply the most extensive set of analytics available in the market to help Iowa maximize their program savings, identify and remove fraudulent providers, and maintain a collaborative and trusted partnership with the Iowa Medicaid provider community.

Iowa Medicaid Program
Governor Terry Branstad said "The savings are six times greater than the overall cost of the program integrity contract," Branstad said. "These savings help us provide better care for 400,000 Iowans in need, without reducing provider rates or trimming services."

To do this, we deploy a variety of analyses that validate cost avoidance opportunities through changes in reimbursement policy, covered services criteria, changes to program structure, and a variety of other mechanisms by which the State can reduce expenditures while simultaneously improving care

services to recipients. Over the first four years of the contract, we prevented and recovered $135 million in improper claims, thereby exceeding Iowa's 4-year savings target of $95 million by an additional $40 million. The most recent Medicaid Integrity Group (MIG) audit also identified our cost avoidance methodology in Iowa as a CMS best practice that other states should adopt.

State of Kentucky

Kentucky Medicaid Program
We have identified over $50 million in potential improper payments, recovered approximately $34 million in overpayments and identified about $3 million in underpayments.

As the Recovery Audit Contractor (RAC) for the Kentucky Medicaid program, we significantly exceeded FWA savings targets set by Kentucky as well as established a model RAC program that has been identified by CMS as one of the most productive in the country. We use an extensive inventory of analytics to provide identification, audit and recovery services. These services ensure providers are paid accurately; uncover FWA; identify problems within the State's policies, regulations or claims system; and recommend changes for the Kentucky Medicaid Program.

We ensure that the administrative burden to the provider community is minimized through the use of consistently refined analytics that significantly reduce the false positive rate, thereby reducing provider abrasion and helping enhance a collaborative partnership with the Medicaid provider community. As an example, at the most recent National Association of Medicaid Program Integrity (NAMPI) meeting held in August 2014, our Kentucky Medicaid customer presented its significant success with the RAC program, especially in the high success rates (e.g., low false positive rates) with our Demand Letter Audits, of which the DRG analytics resulted in an "identified versus recovery" rate of 99 percent. We used the following types of audits:

- Demand letter audits (automated review)
- Desk audits in which medical records are requested from providers and reviewed at our site, which includes predictive modeling
- Field audits at provider locations
- Extrapolation audits involving medical record reviews

The Kentucky program has identified over $50 million in potential improper payments, recovered approximately $34 million in overpayments and identified about $3 million in underpayments.

Local Oversight

The Louisiana FWA Program is managed by Larry Smith, program integrity officer, who works in our local Metairie office. Mr. Smith has more than 30 years of health care industry experience with more than six years of experience in compliance. He has direct accountability to chief executive officer April Golenor and the chief Medicaid compliance officer Chris Zitzer. He oversees and monitors the enforcement of the FWA compliance program and ensures the program is compliant with the contract, as well as state and federal rules and regulations. Mr. Smith and Ms. Golenor, or chief operating officer Karl Lirette, will continue to meet with DHH and the state's Office of Attorney General. Please refer to

Figure 53. Mr. Larry Smith is the Louisiana program integrity officer and oversees and monitors the enforcement of UnitedHealthcare's FWA compliance program.

our response to V.2 for a detailed description of our corporate program integrity division including Mr. Smith's level of authority and reporting relationships.

Prevention Activities

We deliver best in class prevention and outreach service and are continuously evaluating opportunities to expand our program. The main components to our FWA prevention approach are:

- Safeguards to prevent payments to excluded providers
- Provider education, awareness and outreach
- Employee Education and training
- Intensive coding review
- Prohibited affiliations

Iowa Medicaid Program
"We are pleased with the innovative approaches Optum has instituted," Vermeer said. "We've put those who deliberately seek to defraud the system on notice that we're using some very sophisticated techniques to thwart their efforts. For those who make mistakes or are misinformed, there's an educational component to the program that our Medicaid providers have found helpful."
- Jennifer Vermeer, director of the Iowa Medicaid program

Safeguards to Prevent Payments to Excluded Providers (15.4)

We combat FWA both prospectively (before we pay claims) and retrospectively (after we pay claims). Our FWA Program seeks to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payment. Internal controls are supported by comprehensive policies and procedures designed to prevent, detect and report known or suspected FWA activities.

We understand that Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for emergency services. As such, we will be responsible for the return of any money paid for services provided by an excluded provider.

Provider Education, Awareness and Outreach

Proactive provider and stakeholder outreach is essential to the successful implementation of any fraud, waste, abuse program. Without appropriate outreach and education, provider pushback and appeals can occur. More concerning is that providers may become disenfranchised from the Bayou Health program, impacting the State's ability to provide services to the Medicaid population. In our experience, the vast majority of providers support properly designed and implemented FWA programs.

Our claims analytics also provide in-depth information about each provider's billing pattern(s) and how that billing may deviate from peer group norms. Providers identified as outliers may receive a letter detailing their abnormal billing trend including examples of the claims that were evaluated. If, after an agreed upon time period following the letter date, there is no change in the billing pattern, an audit including review of medical documentation is considered.

Employee Education and Training

Compliance and fraud waste and abuse training is required of all employees and contractors. Required training content includes, but is not limited to, general Compliance and Ethics Program and FWA Program expectations, a review of pertinent laws and regulations, examples of potential FWA issues and schemes, and a review of the resources available for reporting

suspected instances of potential FWA. This training is mandatory upon hire and annually thereafter. Specialized training will also be provided on compliance and FWA risks based upon health plan-specific requirements as well as the employee's job function and responsibilities, in accordance with Section 15.2.3.11.

Compliance training is required within 30 days of hire and is a condition of employment. Supervisors are responsible for ensuring that each employee completes the applicable compliance training. Compliance training is required for all employees, managers and directors, and applicable company contractors. Sample training topics include but are not limited to:

- Compliance, Ethics and Integrity Program Overviews
- Fraud, Waste and Abuse Education
- False Claims Act and Whistleblower Protection Education
- Privacy and Security Education and Awareness
- Records Management Education
- Conflicts of Interest Education
- Pharmacy Interactions Education
- Harassment Prevention Awareness
- State-Specific Training and Education

Mandatory training is managed through our Web-based LearnSource system, which automatically tracks required training for all employees. Completion of training programs is documented through the LearnSource system and records are maintained by our human capital function. LearnSource generates automated reminders for staff who are due to complete annual lessons and to managers whose staff has not completed the required lessons. Additionally, Compliance and Ethics Program staff reviews compliance training completion reports on a quarterly basis to monitor ongoing completion rates and facilitate follow-up activities with the employees and management staff.

Intensive Coding Review

This is the most in-depth form of provider engagement with the goal of building a relationship with a facility or large physician group to engage in ongoing dialog related to coding issues we observe through our clinical review findings. This solution was conceptualized for providers with a wide range of coding issues and who require more than a provider education report to remedy the issues.

Prohibited Affiliations (15.3)

We adhere to requirements prohibiting the hiring, continuing to employ, contracting with, or making payment to persons or entities, including those with ownership or controlling interest that have been excluded, debarred, or suspended from participation or procurement with federal or State health care programs, as required. We also adhere to state contract requirements specific to state sanction screening results.

We proactively conduct:

- Office of Inspector General (OIG) List of Excluded Individuals/Entities(LEIE)
- Louisiana Exclusion Database (LED)

- The System of Award Management (SAM)
- Other applicable sites as may be determined by DHH

We conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered will be reported to DHH within three business days. We understand that any individual or entity that employs or contracts with an excluded provider or individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized or prescribed by the excluded provider or individual. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. Additionally, we acknowledge that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid members.

We will notify DHH within three days of the time we receive notice that action is being taken against us or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which may result in exclusion, debarment, or suspension of UnitedHealthcare or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

Detection Activities

The relationship between prevention and detection is symbiotic. Through our experience, we understand that FWA is not isolated to payers. If we detect FWA, chances are other MCOs in the state are experiencing similar patterns with the same providers. As we have done in other states, such as Tennessee, we will collaboratively work with other Louisiana investigators to identify potential offenders and aggressively impose appropriate, corrective and disciplinary actions to promptly reduce the potential for recurrence and support ongoing compliance with applicable regulatory requirements.

To help ensure health care dollars are applied as effectively as possible, we provide a variety of tools and services to combat FWA. The main components to our FWA detection approach are:

- Dedicated local investigative team
- Pre-payment provider detection methodologies
- Investigations
- Overpayment detection methodologies
- Retrospective (post payment) services
- Surveillance of member utilization
- Provider service profiling
- Member utilization profiling
- Claims editing tool
- Claims Cost Management and Hospital Bill Audit Program

Dedicated Local Investigative Team

The special investigations unit (SIU) comprises highly qualified investigators with significant experience in health care and prescription drug fraud and abuse, industry business practices and systems, infrastructure, plus knowledge of federal and state law enforcement and litigation practices. These investigators are responsible for conducting investigative activities and

operations. They also have knowledge and experience in intelligence (e.g., fact-based)-led investigative practices and relevant legislation. Their investigation functions also include presenting evidence in litigation to support civil and criminal prosecutions. Upon contract award, we will deploy our program integrity team of 43 staff which includes eight Louisiana-based staff. Our staff will include our Louisiana-based investigators and we commit to meet the state requirement of one investigator per 100,000 members located in the state. They will be accountable to Mr. Smith.

Pre-Payment Provider Detection Methodologies

Our proposed analytics function is staffed by an expert team that includes clinicians, bio-statisticians, and health care coding experts and includes a research and development function that uses continuously updated claims data to discover new methods of detecting inaccurately paid medical claims. In an effort to provide its clients with the broadest detection suite possible, the analytics office employs a variety of cutting edge solutions including link analysis, peer comparison, vector analysis, distance vector, acceleration, numbers theory, and various forms of regression analysis. Our multi-dimensional analytic capabilities are developed both pre-payment and post-payment and at the claim level and provider level.

We employ an integrated approach in providing detection services to each of our clients. Our analytic solutions are customer-specific and are developed using a mixture of descriptive analytics, predictive modeling, data mining, machine learning, forecasting, optimization, simulation and experimental design. Solutions are organized by detection method into three categories: Rules, Peer Analysis and Predictive Scoring Models. By leveraging the full breadth of its health care expertise during ideation, and customizing for each client during development, we are able to provide a comprehensive suite of solutions aimed at detecting and preventing the improper payments specific to each client's business. The three categories are:

- ***Analytic Rules*** are the traditional detection method for improper payments to health care providers and are an integral component of our Payment Integrity analytic suite. A rule is a formula or set of steps used to uncover an improper payment to a health care provider. Rules are typically used when an improper payment scenario is well understood and rely heavily on clinical expertise during ideation and development to achieve the high degree of accuracy needed for effective implementation. Rules can be used to identify aberrant billing patterns at either the claim or provider level, and can be applied either prospectively or retrospectively, given the client's specific business need. To increase the accuracy of its rules, we manually review the applicability of each rule to a given client and use operational feedback to monitor and improve the performance of each rule for that client.
- ***Peer Analysis*** is a detection method used to identify improper payments to health care providers. Like a rule, a peer analysis module is also a formula or set of steps. Additionally, it incorporates relative peer group information and is used when situational claim characteristics such as type of specialty, geographic location, etc. provide an opportunity for further analysis. Peer analysis modules identify aberrant billing patterns at the provider level and like rules, rely heavily on clinical expertise during ideation and development to achieve the needed level of accuracy. Peer analysis modules are only applied prospectively and their utilization is also manually reviewed for applicability to

each client. Operational feedback is again monitored and used to improve future performance of all peer analysis modules.

- ***Predictive Scoring*** models make up the third category of detection method used within our analytic offering. They are algorithms that group or predict an outcome or an event based upon predictor variables and are used to identify anomalous billing behavior at the claim level. They can be applied either prospectively or retrospectively, based on business need, and application is dependent on the amount and type of data received from the client. In addition to identifying improperly paid claims, predictive scoring models can often be used to uncover previously unknown concepts as well as be applied to operational processes to increase efficiency and productivity. We work closely with each of our clients to determine which mix of applications will provide the maximum value and use operational feedback to continually improve model performance.

Investigations

Once a claim is identified as suspect, we will send the provider a request for medical records to support an administrative review. Reviews are conducted by a team of RNs, LPNs, and certified coders and aimed at determining whether the codes billed were indeed the services performed. Review outcome information is captured to allow for refinement and enhancement of this analytic.

Overpayment Detection Methodologies

We employ multiple detection methodologies to prospectively detect FWA, including electronic data analytics and provider audits. These methodologies are intended to identify aberrant and excessive billing practices and trends, inappropriate treatment, fictitious and unqualified providers, and fictitious and ineligible members.

Our system for monitoring and auditing to verify compliance with regulatory and contractual requirements includes:

- ***Member Input:*** We encourage members to monitor the quality of care provided, including worker FWA and to report any problems or concerns to the case manager. In addition, we will send members an explanation of benefits, as required by Section 17.5, to provide additional visibility for services being billed on their behalf.
- ***Pre-payment Data Analytics/Automated Pre-Payment Claims Edits:*** We mine claims before payment to identify various types of billing errors and irregularities. The results of this mining assists with identification of suspected FWA for follow-up prospective audit and retrospective investigation.
- ***Post-payment Data Analytics, Automated Post-Payment Claims Edits and Post-Processing Claim Review:*** We apply post-payment claims edits and multiple levels and types of electronic data analysis to claims already paid to prevent future payments induced by FWA and to identify retrospective audit, investigation and recovery opportunities.
- ***Payment Error Analysis:*** We analyze paid claims to identify various types of billing errors and irregularities. This analysis contributes to the identification of suspected instances of FWA for further analysis.

- ***Trend Analyses:*** We review industry trends and information from multiple industry and professional association sources and assess their potential impact on our benefit programs. This information is used to inform future FWA activities.
- ***Data Mining Queries/Aberrant Billing Patterns:*** We maintain libraries of electronic data mining queries (DMQs) and aberrant billing patterns (ABPs) that include electronic queries and algorithms designed to identify suspected FWA based upon known or suspected schemes and practices. These DMQs and ABPs include general queries and criteria applicable to all claims (e.g., gender inappropriate services) as well as queries and criteria tailored to common Medicaid FWA schemes. We use these DMQs and ABP criteria to perform electronic analytics of claims data and to analyze provider claim trends. We routinely identify, propose, test and implement new DMQs or ABPs as new schemes and methods to detect suspected FWA are identified.
- ***Provider Audits:*** A detailed provider audit can detect FWA or other improper billing practices. We perform selective audits of certain providers to look for potential FWA. Providers are selected for audit using various sampling criteria (e.g., random, statistical) as part of a provider monitoring program. Provider audits may be a component of retrospective fraud and abuse investigations.

Questionable Claims from Ambulance Companies

Ambulance providers bill Medicaid at two different levels of service: advanced life support (ALS), which is reimbursed at approximately $125 per trip, or basic life support (BLS), which is reimbursed at about half the ALS rate. Our analysts compared ambulance claims with follow-up hospital and ER treatment, using the logic that ALS ambulance services would require extensive follow-up hospital services. We discovered that three ambulance providers repeatedly overbilled the state Medicaid program, and turned those results over to the U.S. Attorney. As a result of the follow-up investigation by state and federal authorities, one of the ambulance companies agreed to pay $390,000 to resolve allegations that it violated the federal False Claims Act and the state's Medicaid False Claims Act by upcoding ambulance claims. The other two companies are still under investigation. Another 38 ambulance companies were asked to do a self-audit on the way they coded claims based on the our investigation. Along with the state, we also conducted educational outreach with providers who significantly exceeded state and national averages for ALS claims.

Retrospective (Post Payment) Services

In addition to our robust prospective offering, we use retrospective claims data to identify irregular or suspicious practices or billing patterns. Retrospective claims analysis is performed on adjudicated claims for services which were previously rendered. Providers' coding and billing practices are compared to peer providers, per coding guidelines, by specialty and region, to determine patterns of inappropriate and irregular billing.

Based upon mutually established criteria, referrals from a variety of internal and external sources will be investigated and analyzed to identify fraud and abuse. We will work to fully develop a case, and perform services such as medical records audits, background checks, trending and financial loss quantification. The case will then be documented and if it is determined to be potential fraud, this will result in a referral to MFCU and DHH.

- ***Incorporation of Louisiana Policy and Local Knowledge into Analytics:*** There is a consensus among experienced state Medicaid program integrity leaders that, for

Medicaid FWA analytics to be highly accurate, they must be customized to reflect the unique features of the state's utilization profile, program design and policy. As a result, we tune our predictive models and other analytics using a formal methodology that accounts for the unique attributes of the state's program. This reflects our in-depth understanding of how state Medicaid programs differ from each other and from health plans. This process relies heavily on input from local subject matter experts to refine analytics processes and results.

- ***Rapid Feedback to Continuously Improve Detection Analytics:*** To effectively prevent improper Medicaid payments without undue false positives, our FWA analytics need to not only be highly customized to the Louisiana program, they must also rapidly adapt to changing provider billing and recipient utilization patterns and incorporate results from pre-payment and post-payment review efforts. Our predictive models are designed to adjust model pattern detectors in near real time based on new claims submitted and review results entered into a single case management and workflow system. This case management system was designed from the ground up for pre-payment and post-payment review of claims identified by analytics and referrals and connects seamlessly to analytics processes to ensure no lag in results transmission and no loss of data quality. A key component of this design is to allow reviewers to quickly and effectively convey granular feedback to the analytics engine and to flag false positives for later root cause analysis.

By adapting to changes in billing and utilization patterns and rapidly incorporating the results of review efforts, the analytics engine ensures consistent and accurate claims selection to maximize cost avoidance and minimize provider abrasion.

Surveillance of Member Utilization

An additional requirement that is critical to the retrospective (post-payment) FWA efforts of a Medicaid program is the effective provision of member and provider utilization services. Per the Code of Federal Regulations (CFR) 456.23, 456.3 and 456.4, we use industry-proven technology that meets or exceeds the CMS Program Integrity Checklist requirements for surveillance and utilization control programs that address both providers and members. We focus on instituting safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments. Additionally, we assess the quality of the services being provided.

Our post-payment review process allows our team to develop and review the following:

- Provider service profile
- Member utilization profiles
- Exceptions criteria

As we identify exceptions, we address mis-utilization practices of both members and providers. The following information provides additional detail regarding our industry-leading capabilities associated with surveillance and utilization control.

Provider Service Profiling

- Produces comprehensive statistical profiles of provider health care practices by peer groups for all categories of service(s) authorized under the Medicaid program.
- Automatically identifies deficiencies and generates reports on levels of care and quality of care by provider type.

- Automatically reports on the details of the practice of providers identified as exceptions or outliers.
- Provides the capability to profile provider groups and individual providers within group practices.
- Automatically identifies exceptions to norms of practice established by the agency for any type of provider covered by the State plan.
- Displays all data by national provider identifier (NPI) or by a subset of the provider's practice.
- Profiles primary care case managers, including all referrals and other services received by their members.
- Performs analysis of rendering, ordering and billing practices to generate reports of aberrant utilization or billing patterns.
- Applies clinically approved guidelines against episodes of care to identify instances of treatment inconsistent with guidelines.
- Generates early warning reports of high-cost services and service mis-utilization based upon current payment data to quickly identify high-volume practices.

Member Utilization Profiling

- Automatically identifies exceptions to norms of utilization or quality of care standards established by DHH for any type of beneficiary covered by the State plan.
- Tracks federally assisted program participants separately from other categories of assistance.
- Identifies members who exceed program norms, ranked in order of severity.
- Identifies services received by members who are enrolled in selected programs.
- Identifies services received by members who have specified diagnoses.
- Links all services to a single member regardless of the number of historical changes in member ID.
- Profiles all services provided to a member during a single episode of care.
- Provides a methodology and generates a report to classify treatment modalities into peer group categories, by diagnosis or range of diagnosis codes.
- Has the capability to generate reports of individual members by peer group.

Claims Editing Tool

Nationally, in 2013, our Program Integrity Unit prospectively saved $615 million in our Medicaid and D-SNP programs using proven software and tools to perform real-time accurate claim editing for our Medicaid contracts. Claim editing is achieved through embedded Facets core payment edits supplemented by iCES, an additional claim editing tool. Our systems support Health Care Reform mandates, including **National Correct Coding Initiative (NCCI)** bundling, **medically unlikely event (MUE)** and health care acquired conditions.

The iCES tool rigorously reviews all claims before payment. We manage reimbursement policies applied to professional and institutional claims through the editing capabilities of iCES. The iCES rules are the programmed instructions, representing reimbursement policies and standard coding rules, which analyze claims. The iCES tool is equipped with a knowledge base that

contains up-to-date code sets, updated regularly as rules and codes change, as well as current industry standard guidelines for many codes and claim situations.

Among other edits, iCES screens for unbundled codes; upcoded, invalid and duplicate codes; code fragmentation; member age (if a CPT code is age specific); patient gender (if a CPT code is gender specific); place of service (must be appropriate to the procedure performed); pre- and postoperative intervals (days); and modifiers (that verify a modifier is billed with an appropriate CPT code). iCES identifies providers who have been flagged, based upon factors such as previous suspect billing practices.

Claims Cost Management and Hospital Bill Audit Program

Nationally, in 2013, we prospectively saved $150 million through additional claims cost initiatives to ensure payment accuracy including high dollar claims review. These pre-payment targeted claim reviews ensure payment accuracy. All claims greater than $10,000 go through in-depth review to ensure processing accuracy. Reimbursement methodologies and outlier reviews are also conducted to ensure facility charges are appropriate.

Claims are also reviewed on a post-payment basis to identify any overall gaps in the claim payment process or opportunities for improvements. This may be done by reviewing claims from specific providers, specific types of services, specific pricing methodologies or other targeted opportunities.

All the above activities are performed to ensure our systems are setup and paying correctly. This way we minimize overpayments and inappropriate expense to the state. These are all part of our claims editing and payment accuracy processes. These programs are in addition to the tools we deploy to detect FWA.

Reporting and Reporting Tools (15.1.16 and 15.5)

Our Compliance and Ethics Program complies with the reporting of suspected or confirmed FWA described in Section 15.1.16. We cooperate with all state and federal agencies, including the MFCU, in investigating fraud and abuse. Our methods for identification, investigation and referral of suspected fraud cases comply with 42 CFR §455.13. §455.14 and §455.21.

TIPS and Referrals

Referrals are received via a dedicated fraud website, fraud hotline and online TIP form. We refer incidents of member fraud to the State of Louisiana Office of Inspector General as required by DHH for investigation. We manage TIPS/referrals as a “case” thereby reducing the likelihood of different units working the same “case.”

Robust Case Management System

We will use an end-to-end case management system that creates a unique “case,” from inception to final resolution. This means that there will be a single, centralized system for managing all “cases” that span the evolution of our FWA capabilities, from detection to referral to prosecution. As a result, overall case management quality increases because of the standardized processes and associated documentation, single source of case management storing, and up-to-date status reports and dashboards. This reporting becomes increasingly timely, easy-to-understand in a highly visual manner. This end-to-end capability ensures that cases are complete and defensible.

Our advanced case management and workflow system contains customized work queues for pre-payment review, post-payment audit, provider education and self-review, and fraud investigation – and seamless referrals between those workflows. This safeguards that auditors and investigators take the most appropriate action for each claim or provider, allowing them to effectively target inappropriate billing while minimizing provider abrasion.

Reporting

We will be responsible for promptly reporting suspected FWA to the state's Office of Attorney General MFCU and DHH within three business days of discovery, taking prompt corrective actions and cooperating with DHH in its investigation of the matter(s). Additionally, we will notify DHH within three business days of the time we receive notice that action is being taken against us or our employees, network providers, contractor or contractor employees. As outlined in Section 15.5.2, our reporting will include, but will not be limited to:

- The number of complaints of fraud, abuse, waste, neglect and overpayments made to us that warrant investigation
- The number of complaints reported to our program integrity officer
- At a minimum, we will provide the following information for each complaint that warrants full investigation:
  - Provider name and ID number
  - Source of complaint
  - Type of provider
  - Nature of complaint
  - Approximate range of dollars involved if applicable
  - Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant

We will continue to attest monthly, on a report format acceptable to DHH that a search of the websites referenced in Section 15.3.3 has been completed to identify excluded parties.

We will communicate with DHH and the MFCU on a regular and ad hoc basis regarding suspected FWA issues, provider/member investigations, provider terminations and suspicious member/provider behavior. We respond to all state agency requests in an expeditious manner with many State requests fulfilled the same day or within 24 hours. We will provide a broad scope of provider and member data and verify that the information is compiled in a thoughtful and organized way prior to submitting to the DHH reporting website.

We ensure that all instances of suspected provider and member claims fraud, waste or abuse are reported to MFCU and DHH and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to Louisiana Medicaid providers' billing anomalies or to safety of Medicaid members that results in a full investigation (42 CFR 455.15).

Where a suspicious provider, person or entity is identified, we will conduct a preliminary investigation in which investigative analytics are applied to claims data for the last three years (if available). Once we file our report, we do not contact the person or entity who is the subject of the investigation about any matters related to the investigation or enter into or attempt to

negotiate any settlement or agreement or accept any monetary or other thing of valuable consideration offered by the provider who is the subject of the investigation in connection with the incident. The FWA Program may find no evidence of FWA, but may identify a need for and conduct education and training for the provider, person or entity in question.

When we determine that a provider or member should be reported, we will notify DHH and MFCU simultaneously. The report will include information on the results of the SIU's preliminary investigation, including but not limited to, any evidence it has on the provider's billing practices (unusual billing patterns, services not rendered as billed and same services billed differently or separately). Along with a notification, we take steps to triage or substantiate these tips and provide simultaneous and timely updates to MFCU and DHH when the concerns or allegations of any tip are authenticated.

The SIU reports instances of potential or suspected provider fraud or abuse to the designated regulatory authorities including DHH, the Attorney General's Office, Departments of Financial Services and Divisions of Insurance Fraud. However, we will work with the State and any State or federal agency charged with the duty of identifying, investigating or prosecuting suspected fraud, abuse or waste.

We will report all tips, for confirmed or suspected FWA to DHH and the appropriate agency as follows:

Deliverable	Agencies Receiving Report
All tips (any program integrity case opened within the previous two weeks)	DHH and MFCU
Suspected fraud and abuse in the administration of the program (reported immediately)	DHH and MFCU
All confirmed or suspected provider fraud and abuse (reported immediately)	DHH and MFCU
All confirmed or suspected member fraud and abuse (reported immediately)	DHH and local law enforcement
Notification by member, based upon receipt of EOB that services may not have been received (report within 3 business days)	DHH and MFCU

Reports are provided on available DHH templates, and made to the appropriate State office(s), containing the required information for each report. The reports contain, at a minimum:

- Name of the provider
- Assigned Medicaid provider number and the tax identification number
- Description of the suspected fraudulent act

We cooperate fully in any investigations by regulatory and law enforcement agencies or in any subsequent legal actions that may result from such investigations. We also follow all applicable contractual and regulatory requirements concerning what actions are to be taken after filing a report.

In addition, we will notify DHH when we deny a provider credentialing application or disenroll a provider for program integrity-related reasons or otherwise limit the ability of providers to participate in the program for program integrity reasons.

In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, we will report overpayments made by DHH to UnitedHealthcare as well as overpayments made by us to a provider or subcontractor.

Effective Lines of Communication and Reporting Mechanisms (15.2.3.4)

Mr. Smith is the compliance and ethics official that is available to all local UnitedHealthcare employees related to any program integrity reporting or any compliance concerns. The compliance staff participates in new employee training, encouraging employees to contact him with compliance concerns. Mr. Smith distributes compliance-related information regularly to all employees. This information provides education on a current compliance topic or policy. Additional compliance information is disseminated in highly trafficked areas via measures such as posters and flyers placed in break rooms or close to office printers. Our managers are also expected to discuss legal requirements, company policies, and contractual and regulatory obligations with their staff and evidence their commitment by their own conduct. At our regular all staff meetings attended by personnel serving Bayou Health, regardless of worksite location, Mr. Smith owns a portion of the agenda to provide the team with compliance (including program integrity) information and updates.

All employees are required to report known or suspected noncompliance or unethical behavior. Failure to report suspected violations, misconduct or noncompliance is grounds for employee disciplinary action. Employees and others can report suspected misconduct to Mr. Smith, Ms. Golenor, a supervisor, the legal department, the internal audit department, UnitedHealth Group corporate security or anonymously through the UnitedHealth Group Ethics and Integrity Help Center, a 24-hour option that provides for anonymous and confidential reporting.

UnitedHealthcare monitors issues reported through these mechanisms and continually evaluates the effectiveness of the various communication channels available for FWA reporting and engages with its business partners to adapt to changing business needs.

Corrective Action Activities (15.1.13, 15.1.14 and 15.7)

We agree to comply with Contract Sections 15.1.13, 15.1.14 and 15.7 regarding the review of claims and rights to recoupments or withholding of any program integrity related funds. If we obtain funds in cases where recovery recoupment or withhold is prohibited under the contract, we will return the funds to DHH. As part of our payment integrity process, we have several methodologies in place to ensure that when billing errors occur we can efficiently identify and correct the error.

Audit and Recovery Operations

Nationwide, in 2013, UnitedHealthcare recovered approximately $339 million, using a comprehensive set of services which support identification of claims which were overpaid. We develop specialized algorithms used to data mine paid claims to identify overpayments. Routine algorithms include coordination of benefits, retroactive terminations, duplicates, provider billing errors and processing errors.

In addition to routine algorithms, we use a credit balance audit program which assists facilities in resolving their credit balances on their accounts. If the provider does not have available funds to offset the overpayment, the provider is notified via letter to send in a check. During this time, outreach calls to the provider are conducted until the balance has been resolved. All refund checks received are posted back to the claims system. We will ensure recoveries and credits comply with the contract requirements. In addition, we will not hesitate to communicate with DHH and the MFCU on our efforts to address waste.

Overpayment Recoveries and Rights of Review and Recovery (15.1.13 and 15.7)

We will not pursue recoveries that have already been recovered by the state of Louisiana, either by Louisiana Medicaid or as part of a resolution of a state or federal investigation or lawsuit, including but not limited to false claims act cases.

In accordance with Section 15.1.13, we will not pursue recoveries:

- That have already been recovered by the state of Louisiana, either by Louisiana Medicaid or as part of a resolution of a state or federal investigation or lawsuit, including but not limited to false claims act cases.
- That have already been recovered by the State's RAC.
- When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the state of Louisiana, are the subject of pending federal or State litigation or investigation, or are being audited by the Louisiana RAC.

In addition, we agree to comply with Section 15.7 and will report to and consult with DHH as required by the contract.

Best Practices

UnitedHealthcare Program Integrity Pharmacy Fraud Program

The purpose of our Program Integrity Pharmacy Fraud Program is to proactively identify true fraud relating to the diversion of controlled substances and expensive legend drugs (i.e., pharmacy fraud). The Pharmacy Fraud Program is directed at member and provider level targets with the goal of building cases for referral to law enforcement for criminal prosecution. The Pharmacy Fraud Program is designed to attack the "root" of the problem, mitigate the risk of future harm, and deter others from engaging in fraudulent conduct. The Pharmacy Fraud Program is centered on UnitedHealthcare-developed data analytic tools that measure behaviors deemed to be "red flag" indicators of pharmacy fraud.

The analytic tools are used to support requests for assistance made by state and federal law enforcement agencies who consider us to be an important partner in the effort to combat health care fraud. The tools are also used to generate cases for referral to law enforcement agencies, such as the Drug Enforcement Administration, FBI, HHS-OIG and state MFCUs. The analytic output is reviewed for validation as true fraud by individuals who are highly skilled in the detection, investigation and prosecution of health care fraud. These fraud analysts provide end-to-end management of their lead inventories (i.e., from detection to validation to referral to law enforcement to support of the resulting criminal prosecution).

The Pharmacy Fraud Program was recently used to identify potential pharmacy fraud cases for a large state customer. Numerous cases were referred to the state agency and focused on pill mills, and collectively identified 124 targets for criminal prosecution: 66 members, 15 medical

professionals and 43 pharmacies. The cases were validated without any external activities that could have alerted the member and provider level targets that they were under investigation by UnitedHealthcare for fraud. The validation process preserved law enforcement's ability to engage in undercover operations and other activities (search warrants) to collect indisputable evidence of the fraud. The referrals were accepted by the state agency and are currently being actively reviewed and investigated by state and federal law enforcement agencies.

In August 2014, the state agency's program integrity director recognized the Pharmacy Fraud Program's innovation, and commended UnitedHealthcare for its leadership and willingness to share the Pharmacy Fraud Program with the state agency. The director requested that UnitedHealthcare, the other MCOs, the state's prescription drug monitoring program, and various state law enforcement agencies work together to build out the most comprehensive fraud cases for criminal prosecution. As part of our long-standing commitment to being a good corporate citizen, we support law enforcement's undercover operations through ongoing data analysis, undercover cards, and the payment of false claims (medical/pharmacy) associated with the undercover operations. Of course, any such payments are not included in encounter data.

Innovation Opportunities

It is our intent to implement, for our Bayou Health program, additional capabilities to increase our ability to detect, investigate and recover aberrant claims. We use several fraud and abuse detection tools to support retrospective analytics to help investigators quickly and efficiently detect aberrant behaviors, potential abuse and wasteful practices on all claim types, and to track open cases. These analytics also include member-focused analyses to identify inappropriate utilization of prescriptions and services. The solutions outlined below represent additional innovative tools that will be deployed to enhance our current program.

High Cost Members: Reveals those members whose diagnoses do not seem to warrant the high costs paid for claims on their behalf. This could potentially indicate several suspicious situations: an ID that has been stolen, an ID that is being repeatedly sold by the member for cash or other favors, an ID that is being used by friends and family, an ID that is being billed against by providers who have rendered past services and are now auto-billing, and an ID that is included in lists being sold (usually on the Internet) and many providers are now billing against the ID. For example:

In one program, the High Cost Member module found one member that cost the Medicaid program $36,837 in one quarter but, based upon her claim history over the past three years, had no significant diagnosis that would warrant the cost. In fact, this member had an unusual array of different and repetitive diagnoses during that quarter which instigated an investigator's interest. There were 245 claim lines paid on her behalf, covering 468 different diagnoses. It is highly unlikely that this one member incurred all of these medical conditions in one quarter. It is likely that this member is either sharing or selling her ID or that her ID had been compromised, and is being repeatedly sold on an Internet-based list and billed against by providers who have never seen the patient. This case was referred to the Medicaid Fraud Control Unit.

Browse and Search: A tool that enables investigators to review providers, members and all claim types, using integrated filtering and sorting capabilities to manipulate the claims to easily detect patterns and anomalies, and then export the results for further processing or import into

other software. Our newest capability includes the ability to geo-map the locations of related providers and members.

Analytical Reports: a library of analytical reports to give an investigator supporting information. "Top N" reports are supplied by procedure code, diagnosis code, NDC and claim type. Temporal summary reports are provided for calendar year, quarter, and month for pay to providers, rendering providers and members. Other reports can be added to this library (and refreshed with each data load) as the customer needs.

Analytics

Expanded Fraud Detection: We are exploring advanced capabilities for the identification of collusive and network fraud schemes. This includes social network and other fraud-focused analytics augmented by external datasets.

These analytics are specifically designed to identify inappropriate relationships between providers, program recipients and other related entities, at the individual participant or network level. Suspect individual connections identified may be in the form of a doctor who refers patients to a given surgery center at an unusually high rate. In network scenarios, individual connections often appear innocuous unless viewed in the wider network context. This wider view of cohesive subgroups within a program is often critical in identifying fraudulent billing.

We can also identify a variety of unusual recipient utilization patterns, including those suggestive of recipients obtaining controlled substances for improper uses. We recently collaborated with the California Department of Health Care Services (DHCS) to identify "doctor shoppers" within the MediCal program by analyzing the number of prescribers and pharmacies involved in a member's utilization of commonly abused drugs. In a recent pilot of that program covering two California counties, 66 beneficiaries were investigated, with 51 of those investigations (71 percent of the total) resulting in criminal or administrative action.

Advanced Provider and Recipient Screening: Our provider screening and verification services leverage a variety of external datasets to assess the risk of a provider billing inappropriately once enrolled in a health plan or program. These attributes inform our social network and other analytics to better identify collusion between program participants or connections to other fraud schemes. We also employ sophisticated billing acceleration (spike detection) and provider risk scoring analytics alongside those social network analytics to identify suspect providers after enrollment based upon updated external data or billing and referral patterns evident in claims data.

Industry Leadership

Our national leaders are sought after to speak at national fraud conferences, and Rick Munson, AHFI, vice president investigations for UnitedHealthcare, serves on the board of directors, is currently treasurer and chair of the Annual Training Conference Committee of the National Healthcare Anti-Fraud Association (NHCAA).

UnitedHealthcare is an industry leader with its tools, program and highly seasoned investigative staff. Our staff has tremendous knowledge and possesses a wide array of background and experience related to health care investigations. Our team of investigators has an average of 10 years of experience and brings a wide range of talent and expertise which includes:

- Clinical (MDs, RNs, pharmacists)
- Former law enforcement
- Financial audit
- Criminal justice
- Certified paralegals
- Certified fraud examiners
- Certified coders
- Biostatisticians

Additionally, we invest in continuing education and training for our staff, many of whom who have obtained the following certifications and memberships:

- Accredited health care fraud investigator (AHFI)
- Certified fraud examiner (CFE)
- Certified insurance fraud investigator (CIFI)
- Fraud claims law specialist (FCLA)
- Certified pharmacy technician (CPhT)
- Associate, life and health claims (ALHC)
- Certified protection professional (CPP)

Meeting Additional Requirements of RFP Section 15

Fraud, Waste and Abuse Compliance Plan (15.2)

In accordance with 42 CFR 438.608(a), we have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud, Waste and Abuse Compliance Plan designed to prevent, reduce, detect, correct and report known or suspected FWA in the administration and delivery of services to Bayou Health members.

In accordance with 42 CFR 438.608(b)(2), we have designated Mr. Smith as our program integrity officer. In his role, Mr. Smith has the responsibility and authority to carry out the provisions of the compliance program. He is accountable to the UnitedHealthcare Board of Directors and is directly answerable to Ms. Golenor. Mr. Smith oversees the staff accountable for handling the day-to-day tasks associated with our program integrity plan.

An essential element of our comprehensive, effective compliance and ethics program includes established lines of communication and reporting mechanisms to receive complaints, protect the anonymity of complainants to protect individuals from retaliation and clear processes and structure for addressing compliance concerns quickly and effectively.

Our UnitedHealth Group Code of Conduct and Non-Retaliation Policy prohibits retaliation of any type against persons reporting violations in good faith. And, as part of our compliance program, we maintain an ethics hotline that is accessible 24 hours a day, seven days a week and has provisions for confidential reporting of compliance violations, as required by Section 15.2.3.6.

Our Compliance and Ethics Program, in conjunction with our appropriate business areas, promptly respond to suspected misconduct, ensure appropriate corrective action and regulatory agency reporting if required, for identified non-compliance.

All credible concerns reported or identified of suspected misconduct are reviewed promptly for further action. Timely and reasonable inquiries, including preliminary investigations, are conducted of suspected misconduct by identified compliance, legal or investigations personnel. When appropriate, corrective or disciplinary actions will be taken in response to the associated findings to promptly reduce the potential for recurrence and support ongoing compliance with applicable regulatory requirements. Corrective actions will be designed to correct the underlying issues contributing to program non-compliance or violations and to prevent future program non-compliance.

Our enforcement and disciplinary guidelines are publicized via the UnitedHealth Group Code of Conduct, the Compliance and Ethics Program, Fraud, Waste and Abuse Program, the UnitedHealth Group employee handbook, UnitedHealth Group's policy center and through communication methods such as UnitedHealth Group's intranet sites, memos and newsletters.

We enforce disciplinary guidelines fairly and consistently throughout the organization and managers are encouraged to work with human capital to implement disciplinary measures. In addition, employees who commit criminal or illegal acts may face immediate termination and possible legal action.

An essential element of our comprehensive, effective compliance and ethics program includes education and training programs for employees, members, providers and subcontractors.

Our policies have been developed to reinforce our expectations and provide additional resources for compliance with state and federal requirements and in compliance with Sections 15.2.3.9 and 15.2.3.11.

As part of this organization wide effort, fraud, waste and abuse and general compliance training is required for all UnitedHealth Group employees. This training is mandatory upon hire and annually thereafter.

In accordance with 15.2.3.11 and described in our prevention activities section, require new employees to complete training modules within 30 days of hire related to the UnitedHealth Group Code of Conduct, privacy and security, FWA, organizational Program Integrity resources and expectations, as well as the expectations we have to uphold our commitments to DHH, and other applicable State and federal laws and requirements. As such, our training will include provisions that comply with 42 CFR 438.610 and all relevant state and federal laws, regulations, policies, procedures and guidance (including CMS's Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by DHH, HHS, CMS and the OIG, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its departments.

Medical Records (15.6)

We will ensure compliance with the requirements outlined in Section 15.6 with respect to medical records including that they are accurate and legible, safeguarded against loss, destruction, or unauthorized use and maintained in an organized fashion for all members

evaluated or treated and accessible for review and audit. Our medical records include medical and other clinical data required for quality and utilization management review.

At a minimum, our medical records include the following information:

- Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable)
- Primary language spoken by the member and any translation needs of the member
- Services provided through the MCO, date of service, service site and name of service provider
- Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the MCO
- Referrals including follow-up and outcome of referrals
- Documentation of emergency and/or after-hours encounters and follow-up
- Signed and dated consent forms (as applicable)
- Documentation of immunization status
- Documentation of advance directives, as appropriate
- Documentation of each visit must include:
  - Date and begin and end times of service
  - Chief complaint or purpose of the visit
  - Diagnoses or medical impression
  - Objective findings
  - Patient assessment findings
  - Studies ordered and results of those studies (e.g., laboratory, X-ray, electrocardiogram)
  - Medications prescribed
  - Health education provided
  - Name and credentials of the provider rendering services (e.g., M.D., DO, OD) and the signature or initials of the provider
  - Initials of providers must be identified with correlating signatures
- Documentation of EPSDT requirements including but not limited to:
  - Comprehensive health history
  - Developmental history
  - Unclothed physical exam
  - Vision, hearing and dental screening
  - Appropriate immunizations
  - Appropriate lab testing including mandatory lead screening
  - Health education and anticipatory guidance

We will make available upon a member's request one free copy of the member's record or any part of it. All documentation or records maintained by us or any and all of our network providers

shall be maintained for at least six calendar years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

Comprehensive Compliance and Ethics Program

Our FWA Program is a component of our comprehensive compliance and ethics program. As one of the country's leading health companies, our reputation ranks high among our most important assets. Mr. Smith oversees our Compliance and Ethics Program in Louisiana, including our program integrity functions and the Compliance Committee, and has the authority to report issues directly to Ms. Golenor, to Mr. Zitzer, or if necessary, to the local UnitedHealthcare Board of Directors. Our enterprise-wide compliance and ethics department maintains a comprehensive compliance program in accordance with 42 CFR 438.602 which focuses on the following seven core elements of an effective compliance program:

- Establish written standards, codes of conduct, policies, procedures and controls that promote our commitment to compliance, address specific areas of potential fraud, and ensure compliance with State laws, contract requirements and federal regulations
- Exercise effective compliance and ethics oversight through program governance by a compliance officer and compliance committee charged with operating and monitoring the Compliance and Ethics Program and who report directly to Ms. Golenor and the board of directors
- Develop and implement ongoing, effective education and training programs for all affected employees
- Establish effective lines of communication and reporting mechanisms to receive complaints, protect the anonymity of complainants to protect them from retaliation and establish clear processes and structure for addressing compliance concerns quickly and effectively
- Ensure consistent enforcement and discipline of violations against employees who have violated internal compliance policies, applicable statutes, regulations or state contract requirements
- Monitor and audit compliance and ethics programs for effectiveness
- Respond appropriately to incidents and take steps to prevent future incidents

Our national compliance program provides overarching support for the local Compliance and Ethics Program to ensure the seven elements of an effective Compliance and Ethics Program as specified by 42 CFR 438.608, are in place and upheld and that the needs of Bayou Health members are met and our commitments are upheld. In conjunction, this tiered Compliance and Ethics Program serves as a blueprint for ethical and compliance practices for officers, employees, providers and subcontractors.

Our Compliance and Ethics Program promotes compliance with applicable regulatory and contractual requirements, fosters ethical conduct within the company, and provides guidance to our employees and contractors. Additionally, as outlined above, our program focuses on increasing the likelihood of preventing, detecting and correcting violations of law or company policy.

V.2 Provide a description your Corporate Program Integrity Division including the Program Integrity Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart D in your response) involved in compliance along with staff levels of authority. (10 points)

Ms. Golenor has full binding authority and autonomy over the operational management of the Medicaid program in Louisiana and will remain fully accountable to the State for every aspect of program administration. Under the direction of Ms. Golenor, Mr. Smith oversees the FWA team and FWA program in Louisiana. Mr. Smith is accountable to Ms. Golenor, as well as our national chief Medicaid compliance officer Mr. Zitzer, and has the authority to report issues directly to the UnitedHealthcare Board of Directors.

The oversight and governance structure of our FWA Program focuses on the tools and processes necessary to drive improved program integrity outcomes. Results of the FWA Program activities in Louisiana are reported to the local board of directors, as well as periodically reported to the UnitedHealthcare Government Programs Corporate Responsibility and Compliance Oversight Committee and our national Community & State Medicaid Compliance Oversight Committee. The FWA Program is approved annually through this governance structure.

The governance structure is described below and includes:

- UnitedHealthcare program integrity officer Larry Smith
- UnitedHealthcare chief executive officer April Golenor
- UnitedHealthcare compliance committee
- UnitedHealthcare of Louisiana, Inc., Board of Directors
- UnitedHealthcare chief Medicaid compliance officer Chris Zitzer

UnitedHealthcare Program Integrity Officer

Mr. Smith has established relationships with DHH and state enforcement officials and understands the nuances of the Bayou Health program and the State's expectations on combating fraud, abuse and waste. He and Ms. Golenor are fully committed to protecting the integrity of the Medicaid program by continuing their collaborative, cooperative partnership with DHH and other state and federal regulatory agencies.

Mr. Smith will be the primary point of contact for UnitedHealthcare on issues related to FWA prevention, and:

- Reports compliance activity to the UnitedHealthcare Compliance Committee, the UnitedHealthcare National Medicaid Compliance Oversight Committee and, as necessary, may report issues directly to the local Board of Directors.
- Identifies and manages compliance risk through collaboration with business partners and reports compliance risk and progress made toward remediating risk to the Compliance Committee.
- Investigates and responds to Code of Conduct or other UnitedHealth Group policy violations.
- Ensures policies and procedures are created and maintained to address our local health plan requirements and align with UnitedHealth Group policies.
- Coordinates regulatory audit activity in concert with UnitedHealthcare Government Programs Audit Management and the appropriate functional areas.

- Facilitates response and monitoring of any regulatory corrective action plans (CAPs).
- Reviews processes and functional areas to ensure the Compliance and Ethics Program complies with Bayou Health contract requirements regarding FWA prevention, detection, deterrence and reporting.
- Ensures our Compliance and Ethics Program complies with DHH and federal fraud and abuse laws and regulations.
- Periodically reviews and revises the compliance and FWA policies to meet changing regulations or trends.
- Ensures employees, providers, subcontractors and members receive training and education by overseeing a comprehensive ongoing training program that addresses FWA prevention, detection and reporting; and encourages reporting suspicions of noncompliance, unethical behavior or FWA without fear of retaliation.
- Develops and implements a well-defined reporting process, promoted among all employees, to report suspicions of noncompliance, unethical behavior or FWA without fear of retaliation.
- Ensures there are systems and processes in place to monitor and detect and help investigate FWA.
- Independently investigates and acts on compliance matters.
- Refers potential member and provider FWA cases to DHH or the appropriate law enforcement agency.
- Regularly attends and participates in the Bayou Health MFCU meetings.
- Oversee services provided by any relevant subcontractors.

UnitedHealthcare Chief Executive Officer

Ms. Golenor understands that she is accountable for compliance and provides support to the program integrity officer to ensure the Compliance and Ethics Program is upheld and that all contractual and state and federal requirements and regulations are met and that organizational risks are remediated. Mr. Smith is accountable to Ms. Golenor and reports and escalates information directly to Ms. Golenor.

Louisiana Compliance Committee

Accountable to the local UnitedHealthcare Board of Directors, the Compliance Committee acts as a local oversight and governance body, which assists Mr. Smith in overseeing and monitoring local operations, assessing compliance risk areas, reviewing policies and procedures, discussing Bayou Health program changes and their impact to business processes to evaluate and take action when necessary, and reviewing and assessing the effectiveness of the Compliance and Ethics Program. This committee helps ensure we are adhering to the requirements of the Compliance Plan.

The Compliance Committee meets monthly, or more often if needed, and includes local Louisiana health plan leadership, including Mr. Smith, Ms. Golenor, chief medical officer Dr. Ann Kay Logarbo, chief operating officer, Mr. Karl Lirette and other key leaders.

UnitedHealthcare Board of Directors

Mr. Smith and the Compliance Committee are accountable to the board of directors. Compliance and program integrity information is reported up to the UnitedHealthcare board of directors by

Mr. Smith. Additionally, key compliance information is reported to the UnitedHealth Group board of directors through the Audit Committee.

UnitedHealthcare Medicaid Compliance Officer

The Medicaid compliance officer Chris Zitzer oversees the Compliance and Ethics Program, including oversight of the FWA Program in collaboration with the program integrity officer.

Organizational Chart – Chart D

UnitedHealthcare will have 43 staff including eight in Louisiana to meet the program integrity requirements including activities for the prevention, detection, reporting and corrective action for suspected cases of fraud and abuse in the administration and delivery of services to Bayou Health members. Upon contract award, the additional staff will include the required local investigators who will be part of our Special Investigations Unit.

As illustrated in our organizational chart, Mr. Smith has the level of authority to report issues to the chief executive officer, Medicaid compliance officer, or directly to the Board of Directors and has direct accountability for oversight of our program integrity operation in Louisiana, including the FWA investigators.

[redacted]

Part IX: Systems and Technical Requirements

Section W: Information Systems

W.1 Describe your approach for implementing a management information system in support of this RFP by identifying all information systems (those within and outside your span of control (for claims, clinical and accounting) through which service and utilization data for the La. Medicaid population is processed. Included a Louisiana Medicaid MCO-Program-specific work plan for system readiness and operations that captures:

- All Key activities and timeframes,
- Projected resource requirements,
- Identify the number of dedicated or corporate full-time employees (FTEs) for implementing information systems in support of this contract, and
- Provide the work location of the FTE's before, during and after implementation.

The work plan should cover activities from ramp up, implementation and ongoing operations. (20 points)

Approach for Implementing a Management Information System

We have a management information system that includes such key functions as: member enrollment; benefits and contract configuration; provider claims payment; eligibility verification; care management; encounter data collection and reporting; EPSDT and HEDIS. Our investment in state-of-the art infrastructure is supported by dedicated local resources that will be directed by our Louisiana-based information management and systems director/chief information officer, and our ability to leverage national innovations in hardware and software solutions.

Our approach to management information systems fully aligns with the RFP contract requirements of: Section 16.0 - System and Technical Requirements; Section 18.5 - Encounter Data; the MCO Encounter Companion Guide, Appendix JJ - Transition Period Requirements and Appendix OO- Emergency Management Plan.

Our management information systems provide DHH with:

Local Accountability

- A dedicated Louisiana-based information management and systems director/chief information officer, with five additional dedicated staff to support the information management system function, who has ultimate accountability and oversight of all Louisiana IT development, implementation, operations and Emergency Management Plans
- Implementation and continued oversight from chief executive officer April Golenor and chief operating officer Karl Lirette

Proven Technology supported by local staff and national best practices

- Next generation of enhanced technology called Community Strategic Platform Facets (CSP Facets)
- Hardened, redundant and secure data operations environments
- System scalability to support significant membership growth
- Enterprise solutions that allow us to configure state requirements quickly and economically

- Business continuity of critical operations in response to a disaster
- Dedicated program implementation manager Adam Gillund

Innovation

- Active participation in the Louisiana Health Information Exchange (LaHIE); currently receiving data from 44 hospitals
- BayouCloud – our HIPAA compliant, cloud-based solution that simplifies access for providers clinically and administratively leveraging capabilities such as secure messaging, electronic visits and collaborative virtual rounding between primary care and specialists
- Provider registry and multidisciplinary team care management tools for Integrated Care Model deployment such as patient-centered medical home (PCMH), health homes and Accountable Care Communities (ACCs)
- Deployment of ACCs with safety-net practices across the State provisioning providers with population health analytics and care management tools such as risk stratification and evidence-based interventions
- Deployment of Automated Care Transitions technology (*UHCTransitions*) that takes real-time admission, discharge and transfer information (ADT) from hospitals and triggers alerts and workflow activities directly to Practices. It then uses patient engagement technology to get the member to the practice within seven days of an inpatient or ER discharge

Implementation Activities

Our extensive experience and proven track record of implementation provides DHH with the infrastructure to seamlessly transition new members in to our care management programs upon a solid foundation of technical capabilities.

This experience finds that open and direct communication with key stakeholders promotes collaboration and visibility into information technology processes and requirements, and is critical to any system implementation. To achieve a successful implementation in Louisiana, our approach will focus on five key program management elements during each implementation:

- ***Critical Path and Timelines:*** Document early our critical path milestones and the timeline required for defining, developing and testing the technology prior to go-live.
- ***File Formats and Companion Guides:*** Work together to develop agreed upon file formats and companion guides that clearly define the integration requirements.
- ***Detail Design and Development:*** Develop detailed design documents with input from all key stakeholders to ensure the development outcome meets the integration needs.
- ***Test Files and Testing:*** Develop test files and test scenarios, considering all possible inputs and outcomes. Conduct full end-to-end testing.
- ***Go-live Coordination:*** Team dedicated to coordinating the successful launch of the integration with key stakeholders on call for critical issue resolution.

In addition to meeting these specific contract requirements as we have for Bayou Health since 2012, we also meet all applicable state, and federal laws, rules and regulations, including Medicaid confidentiality and HIPAA and American Recovery and Reinvestment Act (ARRA) privacy and security requirements as detailed in Section 16.1.1.

System Capabilities Overview

CSP Facets is our TriZetto Facets claims platform and is the heart of our architecture with interfaces that optimize the exchange of information to other key systems. CSP Facets provides eligibility, enrollment, claims processing, benefits configuration, capitation and reporting capabilities and provides the source data for other system applications, including our care coordination and case management system, CareOne and our encounter data submission system, National Encounter Management Information System (NEMIS).

Our core systems employ relational data model in their database architectures using relational database management systems (RDBMSs) and can therefore support SQL. Our systems will interoperate where needed with DHH systems and will conform to appropriate standards and specifications set by DHH and by the industry. As we discuss throughout this response, our clinical management suite includes CareOne and BayouCare, a provider care coordination collaboration platform, and our internal finance and accounting tools are integrated through PeopleSoft. For an overview of our system architecture, please refer to the figure below.

Our systems provide processing solutions that include, but are not limited to:

- Eligibility, enrollment and disenrollment management and data exchange
- Provider network management, credentialing, enrollment and confirmation file exchange
- Member and provider information access through secure online portals
- Report generation and transmission
- Care coordination and case management
- Claims processing, edits, adjustments and voids
- Claims adjudication, payment and coordination of benefits (COB) for claims with third party liability (TPL)
- Financial management and accounting

The following Louisiana Conceptual Architecture diagram presents the major components of our management information systems (MIS) interconnectivity and data transport with DHH the Medicaid fiscal intermediary (FI) and Medicaid enrollment broker, in support of the LA Bayou Health program.

[redacted]

This architecture accommodates scalable expansion which allows us to quickly introduce routine upgrades, while giving us the latitude to plan for significant increases in computing needs without risk or material operational impact. The following table provides brief descriptions of our main information systems. The components of our technical infrastructure are categorized into seven main functional areas: Care Management/Clinical systems; Member Management

systems; Provider Management systems; Claims Management systems; Information Reporting; Financial Management and Encounter Management systems; and Information Support.

Systems Capabilities Table

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Information Systems Work Plan for System Readiness and Operations

Our overall implementation work plan is maintained in Microsoft (MS) Project and organized into functional segments (e.g., member services, provider services, clinical, technology, operations); each with a dedicated implementation team that focuses on their specific component of the implementation. This comprehensive project management approach provides the foundation for each functional team to simultaneously achieve the milestones within their units yet stay connected on active interdependencies across multiple functions.

Each functional implementation team reports to Adam Gillund and he ensures contract compliance and proper alignment of resources and staff. **Mr. Gillund has been engaged with implementation activities with the state of Louisiana for more than a year**. He is thoroughly knowledgeable about the current implementation requirements and DHH's future goals and initiatives. He is experienced and has led other successful Medicaid health plan implementations.

Key Activities and Timeframes

The Information Systems work plan is summarized from MS Project into the table below and captures key activities with associated timeframes, from project ramp up, implementation, and ongoing operations.

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UnitedHealthcare is well-positioned to provide high-quality health care services throughout the State to all Bayou Health program members on the operational start date of February 1, 2015. Our IT implementation work plan demonstrates our ability to be prepared for DHH's readiness review beginning in early November. We have detailed processes for ensuring DHH has a complete overview of all implementation and go live activities. We will prepare for and participate in readiness review meetings in accordance with the requirements in Section 19.5 and Appendix JJ Transition Period Requirements.

Projected FTE Resource Requirements

The table below defines project resource requirements in terms of full-time equivalents (FTEs) (1 FTE = 2080 hours) before and during implementation. Also listed in the table is the number of actual employees, by role, who are currently engaged before and during implementation.

Dedicated/Corporate FTEs to Support Initial Implementation Efforts

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Dedicated/Corporate FTEs to Support Ongoing Technical Operations

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We have significant experience working in partnership with DHH to continually refine our managed care information system to meet new requirements and enhance the support of services delivered to our members. Based upon our past experience working with Louisiana we estimate our ongoing continuous improvement IT resource requirements to be 14 resources per year across all software development life cycle (SDLC) disciplines.

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In total, we anticipate the Louisiana program to require **63 IT resources** to support the program [redacted]

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Our Ability to Meet DHH Contract Compliance Requirements

16.1 General Requirements

Technical Approach for Service Oriented Architecture

UnitedHealth Group embraces our Enterprise Service Businesses and fully supports a service-oriented architecture for communications between our internal and to our externally facing applications. UnitedHealth Group maintains strict separation between our internally facing services and our externally facing services, and leverages industry-leading proxy, firewall, virtual private network (VPN), and other technologies to provide secure external communications. As Louisiana looks to adopt this integration pattern and move to more real-time integration, we have the tools, technologies and know-how to assist DHH.

With our public cloud infrastructure and cloud portals, we currently support identity management/single sign-on capabilities with internally and externally hosted applications, master data management for master patient and provider indexes, search/identity matching services against those master indexes, application hosting, public and private cloud partitions, and public and private health information exchanges. Additional applications may be added to our portal dashboard, and attach to our identity management/single-sign-on capabilities, our growing catalog of application program interfaces (APIs), and our search services as needed. Our cloud

infrastructure, available services, and **BayouCloud portal are payer-agnostic**. In the simplest use case, they may be used to host links or apps for the LaHIE and other MCO portals.

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Additionally we support the CORE transaction set for real-time eligibility and claims search and response, specifically the 270/1 and 276/7 transactions enterprise-wide. Becoming a trading partner is a simple, almost self-service activity, with our companion guides, instructions, and contact information for these and other EDI transactions posted on our public provider portal.

Key transactions between our applications leverage real-time services today, with many more planned. Our voice and web portals, for example, use services to connect to our enterprise sources of record and sources of truth for eligibility and claim status, and our web portals connect real-time to our CareOne platform for HRA and clinical plan of care information. The services are available for internal use either via our enterprise service bus or point-to-point.

UnitedHealthcare is transitioning from our traditional web portals to applications hosted within our cloud portal. We are starting with the administrative functions that providers commonly need. The cloud provides a central access point for the suite of UnitedHealthcare websites and applications, many with the simplicity of single sign-on security.

New features and functions can and will be added to BayouCloud that will streamline processes and reduce administrative burdens on providers. Cost savings are achieved through greater use of self-service capabilities for providers and reduction of common work tasks historically requiring internal manual effort. This cloud-based real-time solution is the cornerstone of our goal to provide a single provider platform to bring together multiple websites and both administrative and clinical applications to simplify transactions. With access to the BayouCloud 24 hours a day, seven days a week, provider offices conduct business with UnitedHealthcare when it is convenient for them.

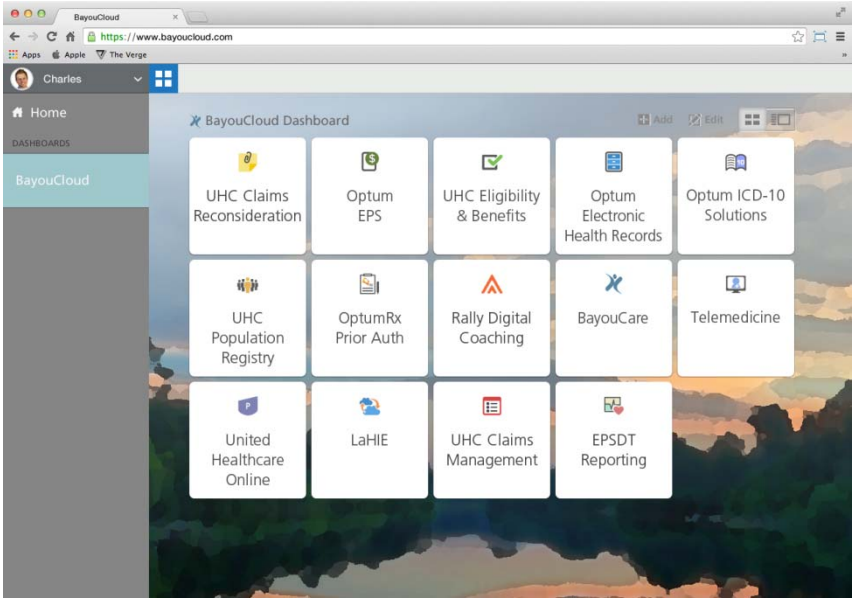


Figure 58. BayouCloud Dashboard. Preview of the BayouCloud portal with a sampling of some of the applications that will be available.

As we deploy this advanced technology solution, **we are ready and willing to offer this infrastructure and expertise for any or all of our data solution components to the State and to other health plans to enable and facilitate data sharing.** For example, to help address EPSDT data collection and reporting across the State and across the awarded health plans, at DHH's discretion and in cooperation with the other health plans, we propose to create and host in our cloud infrastructure a new common repository and web application. This tool will enable all providers to report their EPSDT visit and referral information in a hosted interactive web form that records services members received. This information would then be available for all health plans to report and conduct referral follow ups.

In addition to providing access to *unitedhealthcareonline.com*, BayouCare and other portals, the native cloud applications planned to be in place by the February 1, 2015 operational go-live include:

Administrative

- ***Eligibility and Benefits:*** Our cloud users can search for UnitedHealthcare-managed members (including our Bayou Health members) to find demographic, eligibility and benefit details.
- ***Claims Management:*** Includes claims search detail (payment/check info, edits, codes and line level payment), clean claim status remark codes, and additional reporting features to assist in account reconciliation. Provider offices will manage their accounts receivable with greater ease due to more detailed information being provided.
- ***Claims Reconsiderations:*** Registered users of the Cloud can submit claim reconsiderations with attachments and can view the status of each reconsideration submission.

Clinical

- ***Enhanced Online Authorizations:*** Allows providers to submit attachments for prior authorization requests.
- ***Clinical Portal:*** The ability to link our Integrated Care Model tools into a single platform with single sign on capabilities with the Population Registry, BayouCare platform and Automated Care Transitions.

- ***Electronic Health Record (EHR) Data Sharing:*** Share clinical information from provider's EHR through secure messaging using Direct. We will coordinate with LaHIE and DHH on the use of a common Provider Directory and Master Patient Index
- ***Community Clinical Health Record:*** Working with LaHIE, we will seek to make available to providers the HIE community health application with single sign on access so it is available in a common clinical portal for ease of access.
- ***Telemedicine eConsult:*** Enables PCPs to consult remotely and conveniently with specialists to improve health outcomes for members. This tool has successfully increased access to specialty care and reduced the need for face-to-face office visits by facilitating efficient and secure exchange of health information, and providing increased access to specialists.
- ***Community Collaboration:*** The ability to create online communities of providers and care givers across the continuum of care in a secure messaging environment using secure chat, secure WebEx, and Office of the National Coordinator for Health Information Technology (ONC) DIRECT Trust standards.
- ***Proprietary Systems:*** Various UnitedHealthcare portals, including single sign-on for BayouCloud, for access to administrative functions, prior authorizations and reporting, including EPSDT compliance reporting.

Cloud Portal Usability Study

To gauge the effectiveness of our improved cloud portal, our interactive design services team conducted a usability study in August 2014. The objective of the study was to learn first-hand about users' impressions of our cloud dashboard, navigation, overall look and feel, tile functionality, terminology and content expectations. Participants engaged in a 60-minute one-on-one qualitative session. Each session was recorded and video review was used to conduct in-depth analysis.

Overall feedback was positive with participants finding the content to be simple, accurate and clear**,** and the cloud portal was noted as a huge leap over existing portals. Improvements were identified to organization and grouping of application tiles, and to provide added context/information to individual application tiles. As we continue to update the user experience, additional rounds of usability testing will continue.

Proprietary Systems

As required in section 16.1.9, we have identified in the **Systems Capabilities Table**, above, any systems or portions of systems which are considered to be proprietary in nature.

Procuring and Maintaining Hardware and Software

We understand we are responsible for procuring and maintaining hardware and software resources which are sufficient to successfully perform the services detailed in the RFP. Additionally, we understand we are responsible for all expenses required to obtain access to DHH systems – including systems maintained by other contractors including, but not limited to the Medicaid FI, the Louisiana Behavioral Health Partnership (LBHP) state management organization (SMO) and the Medicaid enrollment broker – or resources which are relevant to successful completion of the requirements of the RFP. Furthermore, we understand UnitedHealthcare is responsible for expenses required for DHH to obtain access to our systems

or resources which are relevant to the successful completion of the requirements of this RFP; including hardware, software, network infrastructure and any licensing costs.

Encryption and Data Protection

Our policy on encrypting non-public data in transit and at rest follows a risk-based approach. Details of implementation of encryption and key management vary by technology platform and application.

- ***Responsibilities:*** Personnel are responsible for safeguarding their communications, no matter the form, to protect the confidentiality of UnitedHealth Group information assets. Confidential or protected information is be reviewed by information owners, resource administrators, and information users to determine if encryption is required when it is at rest or in transit. If encryption is required, only approved encryption tools may be used. UnitedHealth Group personnel, third party consultants, contractors, and vendors may not implement encryption, digital signatures, digital certificates or key escrow tools without prior authorization from UnitedHealth Group Information Risk Management (IRM). The selected algorithm used to encrypt data must use a tested and best practice standard.
- ***Encryption Algorithm:*** Encryption varies by environment but all key systems use AES 256 encryption, which is FIPS 140-2 certified.
- ***Full Desktop Encryption:*** Generally, information classified as “protected” does not reside on a user's desktop or laptop and customer data are stored on secure servers/databases that reside in secure UnitedHealth Group owned and managed data centers. As an added safeguard, all UnitedHealth Group-owned desktops and laptops, and any workstation laptop or desktop used by telecommuters have industry standard full-disk encryption installed, which meets the National Institute of Standards and Technology (NIST) encryption standards. Full-disk encryption is included as part of UnitedHealth Group's workstation configuration.
- ***Encryption and Backups:*** In both mainframe and distributed environments, UnitedHealth Group’s strategy is to encrypt all data at rest without regard to its content or type at the storage media (device) level on both disk and tape. UnitedHealth Group currently has 100 percent of backup tape storage assets encrypted and 100 percent of mainframe storage assets encrypted. In the distributed environment UnitedHealth Group currently has approximately 83 percent of its storage assets encryption capable with plans to increase that percentage to 87 percent by end of 2014. Based upon current funding and the lifecycle maintenance schedule, we are forecasting near completion of our primary array infrastructure by end of year 2016.
- ***Key Management:*** Encryption key owners are responsible for the protection and management of public and private encryption keys entrusted to them. Key deployment and storage needs to be processed in a secure method per UnitedHealth Group IT Encryption Guidelines. Key management controls will be reviewed on an annual basis by the key management owner to help determine whether adjustments are necessary. Keys need to be backed up in the case a recovery is necessary.

Complying with Industry Standards for Physical and Procedural Safeguards

Our technology resources are compliant with industry standard physical and procedural safeguards. To store, restore and recover data and the base platform, we have established a data archive and retrieval system, and we adhere to our information system contingency and disaster

recovery plan. The plan is based upon NIST, National Fire Protection Association (NFPA), and International Standards Organization (ISO) guidelines for disaster preparedness and recovery. Confidential information is handled in compliance with HITECH and HIPAA requirements.

Our wholly owned network of data centers meet or exceed all American National Standards Institute and the Telecommunications Industry (ANSI/TIA) 942- Data Center Tier 1 through 3 standards.

- ***Controlled access:*** Critical data center areas (e.g., server and mechanical and electrical rooms) are secured with proximity sensor card readers and monitored with cameras. There are at least two security officers on-site 24 hours a day, every day. Visitors are required to present and leave photo identification with the security guard and must wear visitor identification.
- ***Cameras:*** Pan, tilt and zoom cameras are provided in internal and external locations. The surveillance images they capture are displayed at the security desk on multiple monitors. Cameras, card readers and intercoms are located at site entrance gates and lobby doors to enhance site control.
- ***Additional physical security:*** UnitedHealth Group's name does not appear anywhere on the exterior of the building. A landscaped earthen berm provides protective separation of the facility from the street. There are no external windows to the server, mechanical or electrical rooms.
- ***Fire retardant capabilities:*** Smoke and heat detection systems are located throughout the building. A multizone pre-action sprinkler system provides fire control. Fire alarm monitoring stations are located throughout the building with a separate alarm at the security desk.

These physical safeguards are typically included in our annual Sarbanes-Oxley (SOX) audit of our general controls.

Use of Flash Drives or External Hard Drives (16.1.13)

UnitedHealth Group's Enterprise Privacy Compliance Program protects the privacy of all health, medical, enrollment and personally identifiable information (PII) obtained as a result of an individual's participation in our health plans. Privacy compliance means we ensure the responsible handling and protection of personal information as we stay focused on the people we serve. All information security policies are available through our Shared Policy and Resource Knowledgebase (SPARK) and include topics such as: access control, application development, data security, personnel security, physical security and information risk assessment, among others.

The information security policies and standards contained within SPARK represent the foundation of security applied to and within UnitedHealth Group. Specifically, the data security policy states employees are not to use portable storage devices, such as USB drives or external hard drives, to store any data, regardless of classification, unless specifically authorized to do so. If the need to use a USB drive or other external portable storage device is necessary, we will first request written approval from DHH. Once such approval is received, we will adhere to FIPS 140-2 hardware level encryption standards.

Computers and Devices Used by UnitedHealthcare (16.1.14)

All UnitedHealth Group computing devices, which access UnitedHealth Group information technology systems, must have an actively running anti-virus or Critical System Protection software package, to identify and if possible, remove malicious code. In cases where removal is not possible, the files are quarantined. We use industry-recognized anti-virus software which is approved by UnitedHealth Group's infrastructure services in accordance with policies set forth by our IRM organization. The protection software automatically updates on a regular basis.

Business and IT management establish and refine procedures to protect information systems and technology from malicious software, such as computer viruses or Trojan horses. Procedures incorporate virus protection, security patches, applicable encryption protection, detection, occurrence response and reporting.

16.2 HIPAA Standards and Code Sets (16.2.1 through 16.2.6)

We maintain systems that transmit, receive and process data in current HIPAA-compliant or DHH specific formats or methods in accordance with Section 16.2.

Our information systems are fully compliant with the requirements associated with HIPAA, P.L. 104-191, as amended or modified. We comply with HIPAA EDI requirements, including the HIPAA-compliant format version. Our systems are fully compliant with HIPAA privacy and transaction and code set standards. We use standard HIPAA 820, 834, 835, 837D, 837I, 837P, 270/271U, NCPDP Post Adjudication History (PAH), 275 claim attachments, 276/277 and 278 file formats for electronic transactions. We are in compliance with the new x12 5010 EDI standards. As needed we can support proprietary flat-file and XML based file formats.

Our Data Release Governance (DRG) program ensures PII and personal health information (PHI) exchanged outside of UnitedHealth Group follows HIPAA policies and industry-standard security procedures. DRG includes a controlled process to register and approve the release of protected information sent to an external entity.

The security services and access control team manages a tool called Secure to facilitate user access to applications and platforms to ensure appropriate system access. Secure requires three levels of approval, thereby enabling efficient auditing and entitlement reviews.

We will collaboratively work with DHH to transmit non-proprietary data relevant for analytical purposes to DHH on a regular schedule in XML format. All eligibility, enrollment, disenrollment and data are exchanged using the External Customer Gateway (ECG). ECG provides a secure electronic transport mechanism for internal entities and external business customers to exchange on-demand or scheduled data files using job automation and control services, including transmission validation. We use ECG to exchange data files with the State. ECG uses Secure File Transfer Protocol (SFTP), Hypertext Transfer Protocol Secure (HTTPS) and File Transfer Protocol (FTP) transport methods. Access is further limited through the use of firewalls and physical separation of processing systems to mitigate unauthorized access.

HIPAA-Conforming Data Exchanges

In compliance with DHH requirements, all HIPAA-conforming exchanges of data between UnitedHealthcare and DHH are subjected to the highest level of compliance as measured using the *HIPAA Business Associate Agreement*, Appendix C, and are part of the contract.

Standardized Batch Transactions

Our system complies with the following HIPAA-compliant standards for information exchange. We will not revise or modify the standardized forms or formats without approval from DHH. Batch transaction types include, but are not limited to, the following:

- ASC X12N 834 Benefit Enrollment and Maintenance
- ASC X12N 835 Claims Payment Remittance Advice Transaction
- ASC X12N 837I Institutional Claim/Encounter Transaction
- ASC X12N 837P Professional Claim/Encounter Transaction
- ASC X12N 270/271 Eligibility/Benefit Inquiry/Response
- ASC X12N 276 Claims Status Inquiry
- ASC X12N 277 Claims Status Response
- ASC X12N 278 Utilization Review Inquiry/Response
- ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products
- NCPDP Pharmacy Claims
- Proprietary flat-file and XML based formats where required

UnitedHealthcare adheres to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with DHH, including HIPAA-based standards and federal safeguard requirements including signature requirements described in the *CMS State Medicaid Manual*. As transaction types change, we will comply with applicable federal and HIPAA standards and regulations as they occur.

16.3 Connectivity (16.3.1 and 16.3.2)

Based upon our current experience in Louisiana, we have established interfaces with DHH, the Medicaid FI, the Enrollment Broker, as well as other trading partners. Interfaces are currently in place to transfer data to and from the State's Fiscal Agent/MMIS contractor in accordance with contract requirements.

We will collaboratively work with DHH to facilitate view-only access to our key systems for DHH personnel authorized for this level of access. We anticipate DHH's primary access will be met with view-only access to our CSP Facets platform over a permanent VPN channel or via our secure Citrix Gateway. This access will enable authorized DHH personnel to have real-time, remote connectivity to our systems from DHH offices. In addition, we can provide guided access with a UnitedHealthcare employee using screen sharing technology to provide access to other systems and answer specific questions.

We currently exchange real-time data with a variety of trading partners including 270/271 eligibility and benefits transactions and 276/277 data exchanges for claims inquires and details. We agree to modify interfaces to mutually agreed upon formats to accommodate future changes as necessary. Our systems conform and adhere to the data and document management standards of DHH and its FI, inclusive of standard transaction code sets as outlined in the *Systems Companion Guide*.

Mailing Address Standards (16.3.3)

Our systems are configured to comply with the mailing standards established by the United States Postal Service. Using these standards helps UnitedHealth Group ensure mail reaches the intended recipient and minimize the costs associated with returned mail. A standardized address is one that is formatted correctly, abbreviated using Postal Service standard abbreviations, and includes all required location information.

Encouraging Providers to Use Electronic Health Records (16.3.4)

As of August 21, we are live and receiving data from 44 hospitals participating with the LaHIE to populate our Population Registry. UnitedHealthcare is the only Bayou Health contractor that has a contract with LaHIE. With the LaHIE data feed and direct hospital data feeds now updating our Population Registry daily, we have been capitalizing on this incredible opportunity to improve care transitions for our patients in Louisiana. The outcomes of this program are discussed further in section W.6. We intend to continue expanding deployment of our Population Registry to reach all providers in the State that serve greater than 100 of our members.

Our Population Registry allows us to feed ADT data to the practices. This in turn permits the practices to manage the transitions in care. It also allows them to intercede with members who are using the ER when a PCP office visit would have been a better choice. In addition, our technology populates 'care opportunities' – preventive testing and diagnostic interventions that help promote wellness – so PCPs can be aware of preventive measures that need to be addressed. Finally, we use Impact Pro algorithms to flag the most vulnerable members and those with special health care needs within each practice so we may contact them and assure their preventive needs are met.

All these interactions rely on technology to meet the triple aim of improved population health, improved individual health and reduced health costs. We maintain three years of member clinical history available to the practice for viewing, including gaps in care on each member. As of September 19, 2014, 18 practices are part of our ACC program with more than 56,500 members active in those practices and to whom we provide our Population Registry. With the implementation of this contract, all contracted PCPs with a panel greater than 100 will have access to our Population Registry.

We have considerable experience in the adoption of electronic medical records (eMR), HIE and Meaningful Use. We are working with Regional Extension Centers (REC) and Medicaid agencies in many of our states to promote the use of electronic health records (EHR) in practices and hospitals, including behavioral health. We are also on many HIE boards across the country and participate in these exchanges. We work with Medicaid agencies to support the deployment of incentives for Meaningful Use achievement. For example in Arizona, as of the end of 2013, approximately 82 percent of physicians in Arizona used an EHR in their daily practice. As of June 2014, approximately $420 million in incentive payments were distributed to more than 10,600 eligible professionals (MDs, DOs, nurse practitioners, physician assistants) and to 250 hospitals for achieving Meaningful Use. In that process we assisted, through the REC, more than 3,000 providers with EHR adoption.

Working in Louisiana we can achieve similar goals by working with DHH, the REC and LaHIE as we did with AHCCCS and others in Arizona. Here are some of the proactive things we have done and can do in Louisiana. Mr. Moreno will participate in and support the efforts of Louisiana Health Care Quality Forum. We can use all of our interaction points (town halls, onboarding,

FaxBlast) with providers to promote the adoption of eMRs. We will publish educational and promotional materials on the BayouCloud. We will create links to LaHIE Community Health Record and promote an eMR Lite solution with them. We will support getting information out to providers regarding educational opportunities on Meaningful Use and eMR systems. These activities will include:

- Ongoing training of provider staff to understand the basics of Meaningful Use and also to help distribute information about free REC, HIE and DHH support services
- Sending fax and email blasts out to Medicaid providers – both regarding REC services and regarding occasional Meaningful Use seminars and educational opportunities.
- Inviting REC, LaHIE and DHH to exhibit at numerous health plan community provider events/fairs to distribute information about EHRs, Meaningful Use, REC services, etc.

As it relates to Meaningful Use Stage 2 requirements we will work with LaHIE and DHH to:

- Provide Direct Exchange accounts and connect to eHealth Exchange (the national network) that will support our participants in meeting the Stage 2 transitions of care requirements
- Support the connection through LaHIE to collect Meaningful Use Stage 2 public health reporting requirements.
- Provide our BayouCloud technology to enable secure Continuity of Care Document (CCD) exchange
- Provide our Automated Care Transitions tool (*UHCTransitions*) to providers for use in care transitions

We encourage providers to use health information technology (HIT) through a range of adoption solutions that create a provider "best fit" – from basic capabilities to more advanced capabilities. We help them in this process by matching the provider's degree of readiness for HIT to an appropriate technology solution that enables them to get started and then helps them move along the continuum.

We have also worked with states, such as Tennessee, to create a common provider infrastructure that can become part of their MMIS platform and therefore be eligible to receive significant funding match from CMS. The promotion and use of common collaborative care transition and care coordination tools is helpful to provider adoption, particularly as you link the services of behavioral and physical health clinics. Referral management is a critical component in reducing the costs of care and thus shared enablement is important.

In Arizona we were instrumental in driving a common statewide HIE led by payers and hospitals. In Tennessee we are working with TennCare and two other health plans on a collaborative shared accountable care platform for their PCMH initiative in which all providers can share a suite common technology. We are willing to do the same in Louisiana with DHH and other health plans.

We will bring best practices from our learnings in Arizona and Tennessee. In fact in Louisiana, we will support providers in obtaining federal grant funds, offer providers zero percent financing through the Optum Bank towards purchase of the Optum Physician eMR software and we will

commit up to $500,000 in $4,000 grants to providers towards the purchase of our Optum Physician eMR software.

We will partner with DHH to promote Meaningful Use to achieve high levels of eMR adoption. Practical use of provider HIT data for population analysis must have a foundation based upon industry standard data exchanges, linking personal health records (PHR) systems via a HIT such as LaHIE. We are committed to working with DHH on future planning and implementation of a single, all-payer PHR at such time that DHH determines, which could perhaps be the best use of the CMS capability. UnitedHealthcare is ready and willing to offer infrastructure and expertise for any or all of our data solution components to the State and to other health plans to enable and facilitate data sharing.

Exchange of Admission, Discharge and Transfer Data (16.3.5 through 16.3.10)

We have the requisite components/infrastructure in place to support successful implementation of integrated care. A critical component of our framework is the employment of HL7 standards. HL7 was created in order for different HIT systems to share and send information using international health care informatics interoperability standards. Connecting plans, health homes, Greater New Orleans Health Connections and other providers to LaHIE are vital pieces of the vision to enable enhanced transition care management, care coordination and other capabilities of an integrated clinical model.

We also see the use of secure messaging as a key data sharing and meaningful use enabler. As presented later, through our BayouCare collaboration platform, we will provide a comprehensive framework and related standards for exchange, integration, sharing and retrieval of electronic health information to support clinical practice and management and delivery/evaluation of health services.

We support comprehensive transitional care and follow up for members moving from one setting to another, particularly those leaving an inpatient facility and moving back to a community setting. Our Automated Care Transitions tool is linked to ADT data from the LaHIE and direct hospital feeds send our providers electronic notifications of ER and hospital discharges. ADT data allows us to understand when members are experiencing a change in care status and conduct appropriate interventions, such as reconnecting the member with their PCP and identifying and implementing changes in their plan of care.

Emergency departments in our network are required to exchange ADT data with LaHIE’s ED visit registry to aid in identification of and creation of policies around high utilizers, drug seeking behavior and chronic disease management. We, in turn, are pulling ADT data into our Population Registry for 7-Day follow ups by the practice. We are receiving these for 44 hospitals today.

Hospitals in our network are required to comply with the data submission requirements of Louisiana Revised Statues Section 1300.111-114, including, but not limited to, syndromic surveillance data under the Sanitary Code of the State of Louisiana (LAC 51:ll.105). We will include the requirements of section 16.3.5 in our contractual requirements with hospitals in exchanging ADT data with LaHIE’s visit registry.

We understand DHH information under this contract is owned by DHH and that we require written permission from DHH to share or publish information.

We acknowledge we are responsible for all initial and recurring costs required to access DHH systems. If DHH contracts with a new FI during the contract, we will comply with transitional requirements as necessary.

If DHH requires UnitedHealthcare to complete an Information Systems Capabilities Assessment (ISCA), we will complete and return the assessment to DHH within 30 days from the date we sign the DHH contract.

Hardware and Software (16.3.11)

Our current desk top workstation hardware and software, network and backup capabilities meet or exceed DHH requirements as specified in Section 16.3.11. Ensuring employees have the tools they need to efficiently access resources is paramount to maximizing workplace productivity. As such, we provide our employees with the hardware, software and office tools that enable them to effectively perform the responsibilities of their position. The information systems and release management (ISRM) team within UnitedHealth Group manages enterprise hardware and software standards.

Desktop Workstation Hardware (16.3.11.1)

Our networked desktop workstation hardware is IBM-compatible and functions using Microsoft 7 or a later operating system.

Desktop Workstation Software (16.3.11.2)

All UnitedHealth Group-managed desktop computers are initially configured with a standard user productivity suite ("standard image") including the Microsoft Windows Operating System, Microsoft Office, Adobe Reader, email, enterprise calendaring and Internet Explorer. Additional software applications that may be needed can be requested through the UnitedHealth Group AppStore. Using our AppStore, all U.S.-based employees are able to request software installation. For any title not available through our AppStore, the employee must follow our established request and approval process.

Corporate Standard Workstation Suite

Application Name (With Link to AVS Record)	Version	Notes
Windows 7 Enterprise SP1	7.1.5.0	Desktop operating system
DotNet Framework 4	4.030319	Prerequisite for many apps
Microsoft Office 2010 Pro Plus Outlook	14.0.7015.1000	Productivity suite updated from v 14.0.4763.1000 with SP2 upgrade
Visio Viewer 2010	14.0.4763.1000	Enables viewing of Visio files
Silverlight	5.0.6118.0	Enables multimedia, graphics and animation
Adobe Reader	11.0.00	Enables viewing of PDF files
Flash Player	12.0.0.38	Enables multimedia, graphics and animation
Shockwave	12.0.7.148	Enables multimedia, graphics and animation
Authorware	7.0	Enables multimedia in eLearning applications
WebEx	28.12.1.16851	Collaboration tools and meeting center
WinZip	16.0.9715	File compression
Outlook Archive†	5.5.7	Email archive solution for Outlook

Application Name (With Link to AVS Record)	Version	Notes
Java Runtime Environment	1.6.0_37	For compiling Java code embedded in Web applications
UHC Master Brand Screen Saver	1.0.0	Screen saver
AppStore Desktop Icon†	12.10.1	For quick access to the UnitedHealth Group AppStore
Cisco Unified Personal Communicator (CUPC)	8.6.2.20563	Instant messaging, voice and screen share
XenApp Plugin†	12.1.0.30	For use with Citrix-based applications
Citrix Receiver*	13.4.025	For use with Citrix-based applications
Internet Explorer (IE) 8	8.00.7601.17514	Web browser – Capable of resolving JavaScript and ActiveX scripts
Symantec Endpoint Protection	12.1.2015.2015	Protects against viruses and malware
Odyssey Access Client	5.20.14913	Controls wired and wireless access to the UnitedHealth Group network
Cisco AnyConnect Client	3.0.08057	VPN access

Email

UnitedHealthcare uses Microsoft Outlook/Exchange 2010 as our standard email platform. This system stores, sends and receives email, and provides contacts, tasks and an electronic calendar.

This application enables us to send and receive encrypted email and attachments both inside and outside our organization to safeguard PHI. Encrypting an email message in Microsoft Outlook protects the privacy of the message by converting it from readable plain text into scrambled cipher text. Only the recipient who has the private key to decrypt (unlock) the message can decipher the message for reading. Any recipient without the corresponding private key sees garbled text.

On an annual basis, employees are trained in the appropriate use of secure email functionality with respect to PHI. Refresher information is also available at any time through SPARK, our online policy and procedure repository.

Other Desktop Workstation Requirement

UnitedHealth Group meets or exceeds the following requirements:

- An office productivity suite that is compatible with Microsoft Office 2007 or later
- Networked workstations that have access to high speed Internet
- Workstations connected to the Internet that have anti-virus, anti-spam and anti-malware software
- Regular and frequent updates of the virus definitions and security parameters for the software applications
- Desktop compression/encryption application that is compatible with WinZip v11.0
- Contractor workstations, laptops and portable communication devices that are protected by industry standard virus protection software that is automatically updated on a regular schedule; installed security patches as applicable and encryption protection at the operating system level

- Compliance with industry-standard physical and procedural safeguards for confidential information (NIST 800-53A, ISO 17788, etc.)

Network and Back-up Capabilities (16.3.11.3)

UnitedHealth Group IT provides dedicated connectivity to a highly reliable nationwide voice and data Wide Area Network (WAN) that connects all health plan locations to the Metropolitan Area Network (MAN) at UnitedHealth Group corporate headquarters. The corporate infrastructure provides access to applications, network storage, telephony and Internet. Local Area Network (LAN) infrastructure within the health plans provides workstation connectivity to local shared devices such as servers and printers, as well as to the WAN.

Security Measures

Access to UnitedHealth Group network and systems is limited through use of firewalls, VPN and physical separation of processing systems. Our customer service applications are protected by these firewalls. All member and provider self-service tools accessible through our secure portals are password protected and use secure Web protocols (HTTPS).

It is the responsibility of the local IT team to work with our national IRM team to protect the confidentiality, integrity and availability of system data. This includes creating, administering and overseeing policies to ensure the prevention, detection, containment and correction of security breaches. The purpose of the IRM program is to ensure management, internal auditors and regulators are satisfied with the security controls that are implemented, and customers and business partners are confident their information is adequately protected.

The IRM infrastructure services security team uses two network-based intrusion detection technologies to identify the potential risk of security breaches:

- ***Intrusion Prevention System (IPS):*** Allows for “detect” and “deny” action
- ***Intrusion Detection System (IDS):*** Allows for a “detection” action

The IPS/IDS systems are configured to detect or protect against malicious traffic. They include real-time alerts and provide detection and prevention of known attack characteristics (e.g., denial of service attacks, worms, viruses, etc.) within the scope of all network-based protocols.

Our IRM team will work in unison with our Enterprise Resiliency & Response (ER&R) and the local IT teams to deploy response mechanisms as soon as they become aware of an event that may disrupt our systems. Within five minutes of a major threat being identified, a bridge line will be open so technical leads can discuss what is happening, understand how it will affect the DHH members and stakeholders, determine what options are available for responding, and set recovery priorities.

The IRM team will systematically keep a log for audit and reporting purposes of access attempts that failed as well as detailed login information such as when the system in question is accessed, by whom, what records are created, viewed, updated, extracted or deleted.

The IT manager will report, either via phone call or email, any security breach in the system to DHH within the timeframe established.

All UnitedHealth Group employees and contractors are required to report privacy and security breaches, whether it involves one individual or impacts thousands. Our key stakeholders – customers, regulators, vendors – count on us to keep their information secure.

Backup Process

For each of our operational locations, UnitedHealthcare has comprehensive backup systems and disaster recovery/business continuity plans that provide for the continuation of business processes in times of power outage or disaster.

We maintain several large-scale data centers in geographically dispersed locations. These data centers are redundantly interconnected, supporting both circuit load balancing and backup interconnection for failover scenarios. We provision all applications with geographically dispersed production and backup infrastructure, allowing full application support in the event an application's primary data center becomes disabled. Our network of data centers, which meet or exceed all ANSI/TIA 942-Data Center Tier 1-3 standards, significantly mitigates risks from data center disabling events and provides 24 hours a day, seven days a week availability of key production systems and data.

System Protection Devices

Our systems are designed with diverse connectivity and redundant devices that are configured to allow fault tolerance and automatic failover in the event of any service or hardware failure. The effectiveness of our emergency preparedness has been tested numerous times in a wide variety of conditions and has been proven effective in every circumstance. Some of the key technologies used include:

- Uninterruptible power supply (UPS) systems for protection from electrical surges, power fluctuations and power outages
- Independent backup generators for power outages, thereby supplying necessary power for a minimum of four days
- Multiple data lines (T1, DS3) from different carriers to minimize WAN downtime
- Redundant network appliances in a failover configuration so that a hardware failure does not bring down the network
- Clustered servers for key applications in an active/passive mode. If one server fails, the secondary server takes over automatically

16.4 Resource Availability and Systems Changes

UnitedHealth Group maintains an enterprise systems help desk called the United Support Center (USC) that provides a single point of contact for all technical, telecommuter and voice support for more than 135,000 end users, using more than 4,000 applications.

Resource Availability (16.4.2)

This help desk provides support for internal and external system users including DHH, its FI and Enrollment Broker staff who have access to our data files or systems. USC can assist with a wide variety of computer and telephone related problems, remote connection and security related issues. When an issue or technical problem is reported to USC, the following process is followed:

1. Immediately upon calling the USC, the caller is given a ticket number for reference and tracking purposes. All ticket numbers are tracked in our help desk service management system throughout the troubleshooting process until closed. Many times problems are corrected while the caller is still on the phone or in live chat with an analyst.
2. The front line analyst uses this tracking software to collect identifying information such as customer contact details, the nature of the query or complaint and the location of problem equipment. Also noted are the business impact of the problem and details about when the issue started.
3. If we cannot resolve the problem immediately, the ticket is forwarded to a technical support group using established ticket classification criteria. Proper ticket classification enables the analyst to sort the issue into the appropriate support queue. These queues facilitate assignment of appropriate support resources, enable proper routing of escalated tickets and allow trend reporting of ticket types.

Help Desk Priority Guidelines

Priority	Definition	**Impacts at least one Tier 1** Vital Business Function	**Does not impact any Tier 1** Vital Business Function
1	An Incident that severely impacts or has the potential to severely impact mission critical business operations or has high visibility to external customers - as defined in the HPSM Service record or as determined by the UCC.	1 Hour	1 Hour
2	An Incident that significantly impacts or has the potential to significantly impact mission critical business operations or has moderate visibility to external customers - as defined in the HPSM Service record or as determined by the UCC.	2 Hours	2 Hours
3	An Incident that impacts a non-critical system or component for multiple users or a single user's ability to perform his or her primary function.	1 Business Day*	
4	An Incident that impacts access to a non-critical system for a single user or a limited group of users.	2 Business Days*	
5	A request that may or may not be related to an Incident. (Used for Service Requests, Request for Information, and Service Complaints)	5 Business Days*	
** Business Days use a 24-hour clock, but do not include weekends. Holidays that* fall on a weekday are currently considered business days.			

Vital business functions are critical business functions, enabled by a specific IT Service, without which the business cannot function.

The USC is available 24 hours a day, every day and is accessible by:

- Calling toll-free 1-888-848-3375 in the U.S.
- Dedicated email address

For DHH personnel and designated DHH contractors including FI and enrollment broker, who have authorized access to our systems, the USC is also accessible by:

- Submitting an online report at *http://it.uhg.com/HelpDesk*
- Live chat at *http://it.uhg.com/HelpDesk*

Our Help Desk analysts resolve 60 percent of issues at the time of the call, with the other 40 percent being routed to other workgroups for resolution. The USC will comply with the following RFP requirements as specified in RFP section 16.4.2:

- Answer questions regarding UnitedHealth Group's system functions and capabilities
- Report recurring programmatic and operation problems to appropriate staff for follow-up
- Redirect problems or queries that are not supported by USC, as appropriate, via a telephone transfer or other agreed upon methodology
- Redirect problems or queries specific to data access authorization to the appropriate DHH staff
- Ensure recurring problems not specific to systems unavailability identified by USC are documented and reported to UnitedHealthcare management within one business day of recognition so deficiencies are promptly corrected
- Use our help desk service management systems to record, track and report all questions or problems reported to USC

Since our help desk is available 24 hours a day, seven days per week, after hours, holiday and weekend calls are always answered by a live analyst and not a recording. As part of our information gathering protocol, callers are asked to provide a call-back number in the event an issue cannot be immediately resolved.

Systems Quality Assurance Plan (16.4.3)

The UnitedHealth Group Testing Center of Excellence (TCoE) develops and implements consistent and repeatable quality assurance (QA) processes across UnitedHealth Group IT Enterprise applications to identify and remove critical defects before time of release. This systematic approach is thoroughly documented in our Systems Quality Assurance Plan. Other quality-related process and procedure manuals are available through SPARK and include topics such as: system development life cycle methodology for major changes to existing technology, quality assurance for application development, program documentation standards, program testing standards, system testing standards and quality metrics, among others.

The Systems Quality Assurance Plan information systems documentation requirements will be submitted to DHH for approval no later than 30 days from the date the contract is signed. In compliance with RFP section 16.4.3, we will:

- Develop, prepare, print, maintain, produce and distribute to DHH distinct systems design and management manuals, user manuals and quick reference guides, and any updates.
- Ensure the systems user manuals contain information about and instruction for using applicable system functions and accessing applicable systems data.
- Submit revisions to appropriate manuals when requesting DHH written approval prior to implementing system changes.

- Make available relevant manuals and reference guides in printed form and online
- Update the electronic version of these manuals immediately, and update printed versions within 10 business days of the update taking effect.

Systems Changes (16.4.4)

Our claims data are housed in our CSP Facets transaction processing system, which serves as the main data source for encounter data extracts. We reconfigure our flexible interface architecture to support current and future requirements. As federal or DHH standards for encounter data exchange change, we will conform to these future standards within 90 calendar days prior to the standard's effective date, or earlier, as directed by CMS or DHH.

When a system update or change is necessary, we will draft appropriate revisions for the documentation or manuals and present the information to DHH 30 days prior to implementation, for DHH review and approval. We understand documentation revisions will be accomplished electronically and will be provided to DHH in an easily accessible, near real-time method. Printed manual revisions will occur within 10 business days of the actual revision.

We will notify DHH staff of changes to core systems within our span of control at least 90 calendar days prior to the projected date of change. This includes, major changes, upgrades, modifications or updates to application or operating software associated with the following core production systems:

- Claims processing
- Eligibility and enrollment processing
- Service authorization management
- Provider enrollment and data management
- Conversions of core transaction management systems

We will respond to system problems reported by DHH, not resulting in system unavailability according to the following timeframes:

- Within five calendar days of receiving notification from DHH, we will respond in writing to notices of system problems.
- Within 15 calendar days, the correction will be made or we will submit a requirements analysis and specifications document. In this case, we will correct the deficiency by the effective date determined by DHH.

Our systems support role-based security that limits access to screens, functions and data, depending on how roles are set up. Role-based security limits viewable screens and actions by group and users assigned to the group. The IT team uses data filters to assign parameter-driven privileges to ensure only select member populations are viewable by the user. Both written procedures and systematic measures are in place to safeguard against unauthorized modifications to our systems. In accordance with SOX requirements, our IRM team audits role-based security on an annual basis to certify users have only the access required to complete their jobs.

Core systems will only be offline during preplanned maintenance windows. Routine scheduled downtime will be posted online. Any non-routine scheduled downtime will be coordinated with DHH and our help desk before scheduled downtime occurs.

We will work with DHH pertaining to any testing initiative as required by DHH and will provide sufficient system access to allow testing by DHH or its FI. We will engage in full end-to-end testing with DHH and/or its FI. Based on documented learnings from our 2012 implementation, this end-to-end testing is essential to ensuring a smooth implementation.

16.5 Systems Refresh Plan

UnitedHealth Group IT management continuously reviews and assesses opportunities to modify, upgrade or replace application software, system operating hardware and software, telecommunications infrastructure, or related policies and procedures. We will provide an annual Systems Refresh Plan within 30 days from the date the contract is executed as detailed in RFP section 16.5, and will include any major updates from our vendors or subcontractors. Our technology refresh plan establishes points along the service life of a product or system to determine when it is optimal to change or refresh various system components to provide the best-of-breed technology to our clients and members.

The plan will also indicate how we ensure the version or release level of all of our system components (application software, operating hardware, operating software) are formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM or SDF for support.

16.6 Other Electronic Data Exchange

The Intranet Document Retrieval System (iDRS) is a Web-based application that provides access to view paper documents that are mailed to us and uses optical character recognition (OCR) to electronically load claims. This application stores scanned paper documents, such as claim and enrollment forms, letters and other attachments and provides the capability to view and retrieve documents electronically via the intranet. These documents are generally stored as TIFF images, and are searchable and retrievable via a film locator number (FLN), used for document tracking. The FLN is cross walked against claims, provider numbers and member numbers as needed to facilitate document retrieval. Strong balancing and control processes are in place to ensure completeness from the mail room to the claims system.

16.7 Electronic Messaging

To accommodate electronic messaging, UnitedHealth Group maintains a fully functioning email system to facilitate communication within our organization as well as stakeholders outside our organization, such as DHH. This system provides the capability for us to send, receive and store email and is compatible with attaching and sending documents created in the DHH standard Microsoft Office software.

We currently use several methods, including VPN, SFTP and secure email to exchange sensitive information with DHH. We comply with national standards for submitting PHI electronically.

16.8 Eligibility and Enrollment Data Exchange

As a current DHH Bayou Health contractor, we accept and process daily enrollment files and monthly enrollment and disenrollment reconciliation files via HIPAA-compliant 834 transactions in the 5010 format. Within 24 hours of receipt, we update CSP Facets, our eligibility and enrollment database.

Upon completion of data validation and load to the CSP Facets core system, enrollment data are made available to our downstream systems including BayouCloud for online eligibility

verification support, as well as to our IVR system for automated telephonic support of eligibility inquiries.

As we become aware of member address changes or telephone number changes, we transmit the information to DHH in the formats and methods specified by DHH.

Members are assigned unique member numbers, which are used on all member-specific materials and for all member-related processing. These numbers are cross-referenced to other member-unique numbers such as Social Security Number (SSN) and DHH-assigned numbers.

Our daily enrollment update process identifies duplicate or potential duplicate member records that exist in our CSP Facets system. The system looks at critical data elements, such as name, date of birth and SSN to identify potential duplicates, which are resolved (after confirmation from DHH).

16.9 Provider Enrollment

UnitedHealthcare uses a multistep process to efficiently load and verify provider contract data according to DHH business rules. This process starts with the receipt of an executed contract, and includes verification of demographic information such as the NPI and the Medicaid identification number. Additionally, the verification process confirms that the provider application and credentialing documentation is complete, including site survey results when applicable. Provider information is loaded into our National Database (NDB) which feeds into our CSP Facets system enabling provider selection and claims payment. As a primary function during implementation, we perform the following activities:

- Contract and claims testing to verify the configuration and fee schedule load
- Review installation accuracy controls and remediate defects
- Monitor end-to-end work flow using PhyCon, a new system designed to support physician contracting operations and provider demographic maintenance

UnitedHealthcare began implementing PhyCon early in 2013 to streamline the process through loading of provider information into our provider systems. As a result, providers experience faster contract loads and increased satisfaction because they can see members more quickly and have claims processed in a timely manner.

To coordinate provider enrollment records, we will use the published list of Louisiana Medicaid provider types, specialty and sub-specialty codes in all provider data communications with DHH and the enrollment broker. In accordance with Section 16.9.1, we will provide the following data files:

- A weekly Provider Registry File to include provider name, address, licensing information, Tax ID, NPI, taxonomy, contract information and other data as detailed in the *Systems Companion Guide*
- A weekly Provider Site File as described in the *Systems Companion Guide*
- A weekly PCP Linkage file as described in the *Systems Companion Guide*
- All relevant provider ownership information as prescribed by DHH, federal or state laws

Our provider management systems include a wealth of demographic and practice information for both participating providers and facilities. This information includes, but is not limited to facility

names, individual practitioner names, contract effective dates, state Medicaid IDs, tax IDs, NPI numbers, practice locations, remit address, telephone numbers, fax numbers, email addresses and non-English languages spoken. All required provider directory elements will be extracted from our systems and published as described below to maintain compliance with specific requirements identified by the Department.

To confirm our data are timely, portable and readily accessible, several systems interface and provide the following data in accordance with Section 16.9.2:

- Audit trail and history of changes made to the provider file
- Automated interfaces with major licensing and medical boards
- Automated alerts when provider licenses are nearing expiration
- Retention of NPI requirements
- System generated letters to providers when their licenses are nearing expiration
- Linkages of individual providers to groups
- Credentialing information
- Provider office hours
- Provider languages spoken

Strategies for Improvement

We are continually working to improve provider data accuracy and streamlining our processes – for both our State partners and our providers – to increase overall satisfaction and simplify program administrative so the emphasis is where it should be, on increased quality of care for our members and reduced costs for our partners and providers.

We identify provider data changes through a number of mechanisms including provider-initiated changes though our provider call center or submission via the online provider portal and through securing updates from the Council for Affordable Quality HealthCare (CAQH), National Plan & Provider Enumeration System (NPPES) or other industry sources of truth.

Through our Network Development and Management Plan, a focus for 2013 was related to an initiative to clean up the provider data in our databases to improve the accuracy of our provider information, thus the information contained on files transmitted to DHH. As part of this initiative, our provider relations team contacted all contracted providers to confirm their demographic information and make necessary corrections to ensure a clean provider database. Our ongoing efforts include using provider advocates, clinical practice consultants, care managers, and any touch points from UnitedHealthcare to providers to ensure our provider database continues to have the most up-to-date, accurate provider information.

In addition, during 2013, we launched the Network Verification Initiative which compared CAQH provider data with the information in our system. As part of our in-depth review, we identified providers requiring outreach. Using a combination of fax and outbound calls, our initial verification activity in Louisiana was recently completed and resulted in more than 2,000 updated records. Other initiatives include developing a fully integrated feed between us and CAQH, educating providers about the value of maintaining current CAQH information, and establishing CAQH as the universal data source. Our goal is to implement CAQH as the industry source of truth and to streamline the provider’s experience in working with multiple payers.

We are deploying additional tools and data mining capabilities to increase data accuracy including:

- Expanding proactive verification outreach campaigns to increase network coverage
- Targeting intelligent data sourcing and analytics to remediate suspect data (e.g., no/low claims spend, age, cred status, last verification date)
- Leveraging portal and CAQH technology to centralize intake channels for contract and demographic data updates

Our team of provider data specialists work full time throughout the year on reviewing and comparing our current provider registry demographic data with any other newly acquired data from any of these potential sources. Our provider contracts contain language that requires the provider to promptly report any change in demographic information to UnitedHealthcare.

16.10 Information Systems Availability (16.10.1 through 16.10.12)

UnitedHealth Group devotes significant corporate resources to ensuring system availability to meet business needs. In Louisiana our dedicated chief information officer and Ms. Carter, IT systems analyst, are supported by UnitedHealth Group IT resources to administer ongoing maintenance and operation of systems and tools within our span of control. Our IT team manages and maintains systems and applications and will perform maintenance based upon an established schedule, which will be shared with DHH as required.

UnitedHealth Group Business Continuity Planning Benefits

- Ensures continuity of care for our Bayou Health members throughout the State
- Reduces the impact of a catastrophic disruption on the Bayou Health program
- Enables a timely and organized response to a catastrophic disruption and minimizes additional loss
- Facilitates communication between internal and external stakeholders.
- Ensures recovery of all critical services to the affected business functions and provides critical services to customers
- Provides a time-phased restoration of all business resources and services impacted by a catastrophic disruption

As an added safeguard, our United Command Center (UCC) organization within UnitedHealth Group IT operates a full time, 24 hours a day, seven days a week, operations team to monitor the health and availability of UnitedHealth Group IT assets. We have both Business Continuity Plans and Disaster Recovery Plans (BC/DR) in place as required by the State. Our strategy focuses on our critical business functions and planning for the worst-case scenario, which can include all forms of disasters, both natural and man-made (e.g., hurricane, flood, fire, terrorism and public health emergencies such as pandemics). We update our business continuity plans quarterly and conduct annual exercises of business continuity plans to train/refresh business recovery teams and prepare for managing through actual events.

We will collaboratively work with DHH, agents of the Louisiana Attorney General's Office or CMS to facilitate the ability to have access to requested data, including extracts or through our Healthplan Manager application for data mining purposes.

Our critical member and provider Internet and telephone-based IVR functions and information functions are available to the applicable system users 24 hours a day, seven days a week except during periods of scheduled systems unavailability as agreed upon by DHH and UnitedHealthcare. This availability is closely monitored by the UCC team.

All other system functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7 p.m., Central time, Monday through Friday. All preplanned maintenance windows are scheduled outside of this timeframe.

These preplanned maintenance windows take into account the timing for data exchanges with DHH's FI and enrollment broker so required systems are available and operational.

In the event of a declared major failure or disaster, our UCC engages with Mr. Moreno and the needed IT teams in active 'war room' response mode to provide coordination of the disaster recovery response, as well as provide notifications and updates to key stakeholders. As noted, Mr. Moreno and UCC will coordinate the response to have the core eligibility/enrollment and claims processing system back on line within 72 hours of when the failure or disaster occurs.

Mr. Moreno will provide detailed notification to DHH, either by phone, fax or email, within 60 minutes upon discovery of a problem either within or outside our span of control that may jeopardize, or is jeopardizing, availability and performance of critical systems during normal business hours. This notification will include any problems impacting scheduled exchanges of data between UnitedHealthcare and DHH or DHH's FI or DHH's enrollment broker. Mr. Moreno will explain the impact to critical path processes such as enrollment management and encounter submission processes.

Mr. Moreno will notify designated DHH staff via phone, fax or electronic mail within 15 minutes upon discovery of a problem that results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day. He will work with DHH to have the applicable work activities rescheduled or handled based upon system unavailability protocol.

As part of our responsibilities, Mr. Moreno will provide information on system unavailability events, such as status updates on problem resolution, to appropriate DHH staff. At a minimum he will provide these updates on an hourly basis, either by phone or email.

In accordance with our help desk priority guidelines, we will resolve and implement system restoration within 60 minutes of official declaration of unscheduled system unavailability for critical functions caused by the failure of system and telecommunications technologies within our span of control. In these cases, we will have system functions restored and services implemented within eight hours of the official declaration of system unavailability.

We understand cumulative systems unavailability caused by systems or IS infrastructure technologies within our span of control cannot exceed 12 hours during any continuous 20 days business period.

Within five business days of the occurrence of a problem with system availability, Mr. Moreno will provide DHH with full written documentation that includes a corrective action plan describing how we will prevent the problem from reoccurring.

Please see our response to W.3 for more detailed information on the steps UnitedHealth Group takes to ensure the continued availability of our systems.

16.11 Contingency Plan

As a health and wellbeing company, we have adopted a business continuity strategy to address the key business interruption risks that stem from the deployment and use of our people,

processes, technology and financial assets in carrying out the day-to-day business operations. In Louisiana our business continuity and disaster recovery efforts are led by chief operating officer Karl Lirette. His strategy focuses on our critical business functions and planning for the worst-case scenario, which can include all forms of disasters, both natural and man-made (e.g., hurricane, flood, fire, terrorism and public health emergencies such as pandemics).

UnitedHealth Group's Enterprise Resiliency & Response Program, which we discuss throughout this section, prevents or mitigates the impact of events that could disrupt our business and the care delivered to our Bayou Health members by quickly mobilizing the corporate and local leadership teams necessary to manage the response and ensure appropriate resources are available to support the response. Effective business continuity planning establishes the basis from which business processes and operations, including service to customers, are resumed, and our event management team structure brings all the components together for a consistent response.

It is our policy that Business Continuity and Disaster Recovery (BC/DR) plans be developed, tested and maintained to limit losses caused by disruptions to critical business operations and to enable efficient and effective recovery. The Enterprise Resiliency & Response Program includes processes and controls to protect the business of UnitedHealth Group, including UnitedHealthcare Community Plan of Louisiana; the life and safety of workforce members; and resources of the organization. We have Emergency Management, BC/DR plans to ensure ongoing customer and provider services through any type of emergency situation. Over our 32-year history, we have maintained business continuity successfully through unscheduled natural disasters and other incidents.

To support our Emergency Management, BC/DR plans, including pandemic preparedness, we maintain policies and procedures based upon the following:

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

Our BC/DR plan is in place and available for on-site review. Our Emergency Management Plan is available for submission to the State, which includes the redacted BC/DR plan. As one of the Bayou Health contractors currently in the State, our Emergency Management Plan complies with

the format in Appendix OO. We will submit the Emergency Management Plan in accordance with the requirements in Section 25.13.

Scenario-based Planning for Disaster Recovery

In the Disaster Recovery Plan we address the risks identified through scenario-based planning of threat and business interruptions. For many companies, disaster recovery means minimizing downtime as they try to restore systems and get them back online. UnitedHealth Group's strategy includes focusing on items that assist in preventing a disaster from taking down systems in the first place.

UnitedHealth Group IT has invested in creating an effective combination of people, process and technology that provides the fundamentals for a proven production method resulting in a stable, scalable environment for our applications to perform at operational excellence. This investment creates the "prevention" which is fundamental to the enterprise disaster recovery program. Prevention is the proactive remediation of known technology exposures. Prevention includes removing the "accidents just waiting to happen."

The Enterprise Disaster Recovery Program is based upon anticipating and planning for the common types of disasters and designing solutions to address them. Disaster protection addresses recovery from the most probable disaster scenarios to the worst case scenario of a total loss of a data center.

Scenario specific risk management includes:

- The central computer installation and resident software are destroyed or damaged
- System interruption or failure resulting from network, operating hardware, software or operational errors that compromise the integrity of data maintained in a live or archival system. To minimize the impacts of threats identified, UnitedHealth Group has implemented redundancies in its network, hardware and software implementation.
- System interruption or failure resulting from network, operating hardware, software or operational errors that compromise the integrity of data maintained in a live or archival system.
- System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system, i.e., causes unscheduled system unavailability. UnitedHealth Group's IT is a health care technology leader in providing computer processing services delivered through UnitedHealth Group IT's portfolio of services with world-class efficiency and effectiveness. Our data centers and technology are self-managed and UnitedHealth Group IT has instituted a formal IT Infrastructure Library (ITIL) based service delivery model.
- Projected Recovery Times and Data Loss for Mission-Critical Systems. Business functions which are classified as critical generally provide for near immediate failover of core services by leveraging geographically dispersed redundant operations and maintain recovery time objectives which are identified in the Emergency Management Plan.

Plan Testing

Our BC/DR plans are tested at least annually through various techniques including tabletop (practical or simulated exercise), structured walk-through (functional), large or full- scale (live or

real-life exercise) and emergency response. A formal test exercise report, identifying any gaps, issues or enhancements identified through testing, is published and monitored for remediation.

When the remediation plan is complete, the plan is certified by the appropriate executive Leadership. The certification process is monitored by the Program Steering Committee. However, in remediating Disaster Recovery Plans we will remain in compliance with Section 16.4.3.6 in Attachment D, we will not perform system maintenance, repair or upgrade activities to take place during hours that can compromise or prevent critical business operations, unless agreed to in advance by DHH.

Our business users participate in a formal business continuity planning process where they identify and prioritize their business applications, ensuring their recovery in a timely fashion. Critical applications can be recovered using disaster recovery plans. The redundant IT disaster recovery systems capability is tested on an annual basis via a complete disaster recovery desktop walk through with the entire disaster recovery disaster recovery team. All of our data security controls, including our BC/DR safeguards and plans, are reviewed as part of an annual SOX audit.

16.12 Off-site Storage and Remote Backup

The Data Protection Infrastructure exists in all primary technology centers. The overall concept is to maintain a primary copy locally, with a second copy geographically dispersed off-site. Off-site copies are maintained within UnitedHealth Group owned facilities to reduce cost and business risks. Data are segregated by production/non-production and functional characteristics, i.e., Wintel, UNIX, Database, Archive. The process is managed by IBM's Tivoli Storage Manager (TSM) product.

UnitedHealth Group's Backup Strategy includes:

- Systems and databases are backed up daily
- The primary copy is held in virtual tape and off-site copies are replicated before the next cycle begins
- Five versions of a file are retained for operational recovery
- Deleted files are kept in the system for 90 days

Operational Backups – Primary vs. Off-Site Copy

Primary (on-site)

- ***Virtual Tape Library:*** System that emulates physical tape system and stores data on hard drives, which facilitates fast backup and restore time
- ***Primary use:*** Operational recovery of systems in place in case of data corruption or accidental deletion

Off-site

- Physical tape libraries located in UnitedHealth Group geographically dispersed location(s)
- Connection to backup server is across the UnitedHealth Group WAN, data are written to the alternate location, eliminating the need for third party off-site storage
- ***Primary use:*** Disaster recovery of systems as defined by the Recovery Point Objective and the Recovery Time Objective (RPO and RTO) at an alternate site.

16.13 Records Retention (16.13.1 through 16.13.3)

The system uses logging, journaling and audit tables to maintain a record of all changes to transactions and data within each application. Our platforms actively store a minimum of six years of historical information including membership, eligibility and claims data for audit and reporting purposes and 10 years in archival systems. In accordance with contract requirements we understand:

- Services which have a once in a lifetime indicator (i.e., appendix removal, hysterectomy) are denoted on DHH's procedure formulary file and claims shall remain in the current/active claims history that is used in claims editing and are not to be archived or purged.
- Online access to claims processing data shall be by the Medicaid recipient ID, provider ID and/or ICN (internal control number) to include pertinent claims data and claims status.
- We must provide 48-hour turnaround or better on requests for access to information that is six years old, and 72-hour turnaround or better on requests for access to information in machine readable form that is between 6 to 10 years old.
- If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

UnitedHealth Group maintains strict data retention policies/standards, which address three business-driven retention requirements. These standards are maintained and managed by enterprise storage services and records information management and encompass the mainframe and distributed environments. A synopsis of these policies/standards is as follows:

- ***Operational:*** Backups that are used for file/database restoration resulting from a near term operational loss of data or disaster recovery (testing or actual) is retained for a period of 15 to 90 days.
- ***Regulatory:*** Records information management establishes the policies and standards for data retention necessary to meet regulatory requirements (SOX, HIPAA, contracts, financial, etc.). **These retention periods range from 3 to 10 years depending on the content, risk and regulatory requirements of the data**.
- ***Legal Holds:*** This process is driven by UnitedHealth Group's legal team. For data relevant to litigation activities, UnitedHealth Group may be required to suspend destruction until the matter has been remediated. Issuance of a legal hold takes precedence over data retention policies and does not require business owner approval to implement.

Full backups are performed weekly with daily incrementals; however, applications may require more or less frequent backups determined by business need.

Retention on full backups may be maintained for upward of 12 cycles (for the monthly runs), 52 cycles (for the weekly), and three weeks of daily incremental updates, prior to recycling/rewriting over media.

Data retention requirements are driven by Records Information Management Policies (RIMS) based upon governance requirements and drive retention periods (preservation orders, SOX, HIPAA). These are separate from operational backups.

16.14 Information Security and Access Management (16.14.1 - 16.14.11)

To ensure compliance with HIPAA privacy requirements, all applications use role-based protocols to ensure that access and the ability to edit records, reports and data are limited to those systems that support the current role and function.

Appropriate access to our systems and platforms is managed by our security services and access control team using the Secure provisioning tool. Secure requires three levels of approval, thereby enabling efficient auditing and entitlement reviews. Automation advances replace manual processes and provide greater efficiencies to accommodate UnitedHealth Group's evolving technology landscape. Some of the benefits of Secure include:

- Use of common logon
- Easy to use interface
- Customized screens based upon user roles
- Multilevel approval functionality with timely system notifications
- System date and time stamps on all actions
- Storage of auditable records

Any employee or contractor with an employee ID can access Secure. The level of access varies from individual to individual. For example, all users can submit a request for new application access for any other user within Secure, but they cannot submit a request to change access for any other user.

Role-Based Security

Role Based Access Control – profiles in our system restrict users to only those functions and information needed to complete their work. Roles are monitored and audited as part of Internal Control Questions (ICQ) for SOX compliance.

CSP Facets supports role-based security that limits access to screens, functions and data, depending on how the groups are set up. Role-based security limits viewable screens and actions by group and users assigned to the group. The IT team uses data filters to assign parameter-driven privileges to ensure only select member populations are viewable by the user. In accordance with SOX requirements, our IRM team audits role-based security on an annual basis to certify users have only the access required to complete their jobs.

Remote User Access Security

Access to UnitedHealth Group network and systems is limited through use of firewalls, VPN, and physical separation of processing systems. Our customer service applications are protected by these firewalls. Our Remote Access Security Standard defines appropriate usage, configuration, care, and security for all individuals who remotely access the UnitedHealth Group internal network. Our remote access solutions for broadband are the Cisco VPN software clients. These solutions provide secure remote access, stable connectivity and quick reconnects and failover. In addition, RSA SecureID strong two-factor authentication is used for remote access.

Users with a documented business reason and management approval may access confidential information remotely.

Sarbanes-Oxley

We undergo an annual SOX audit to verify that data integrity controls are in place for all our systems supporting Bayou Health Integrity controls range from referential integrity in our relational databases, automated job monitoring and record balancing of data exchanges, Public Key Infrastructure (PKI) authentication of external exchanges, administrative and clinical edits, and identifier validations. Intrusion detection and file change control technology is deployed throughout our security architecture model.

The controls we audit and test under the SOX audit are comprehensive of the controls required under the *Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization.*

Our audit requirements mandate that we have evidence to prove that our controls are in place and functioning. We produce system listings, transaction reports, update reports and transaction logs. These are reviewed by appropriate supervisors and managers within IT and the business area.

W.2 Describe results of capability and capacity assessments performed of current systems to ensure they meet or exceed contract requirements.

Describe upgrades or enhancements to existing systems needed to meet or exceed contract requirements. Additionally, if no upgrades are anticipated for this project, describe what and when major system changes/enhancements were last made. (10 points)

Results of Capability and Capacity Assessments

Under the new contract, we will implement the Bayou Health program on our state-of-the-art managed care claims system, CSP Facets, which will be fully implemented by the February 1, 2015, operational go-live date. For this reason, capability and capacity assessments were conducted on CSP Facets rather than the system used to administer our current Bayou Health CCN-S program.

To ensure our systems meet or exceed the capacity sufficient to handle the workload projected for the begin date of operations as well as anticipated growth resulting from Medicaid expansion within the Affordable Care Act, we continuously monitor performance metrics and have plans in place to increase capacity before it is needed. The table below is a snapshot of system performance metrics over the past six months.

Month	CPU/Memory Utilization			
	Database Server		Application Batch Servers 1 - 5[4]	
	CPU[1]	Memory[2,3]	CPU[1]	Memory[2]
March 2014	50%	80%	30%	60%
April 2014	50%	80%	15%	20%
May 2014	50%	70%	15%	20%
June 2014	50%	70%	15%	20%
July 2014	50%	80%	15%	20%
August 2014	50%	80%	15%	20%

[1]CPU utilization is monthly peak
[2]Memory utilization is monthly average
[3]To optimize performance database cache scales with available memory on the server
[4]Application servers were upgraded at the end of March 2014

Capacity is reviewed monthly and the August 2014 review showed a green status for the CSP Facets claims processing system. Considering we are expecting the Bayou Health program to add 6 percent membership growth to the platform we have ample capacity to meet or exceed system workload requirements for the Bayou Health program and the ability to accommodate future enrollment growth, as shown in the table.

Assessing System Capability and Capacity

We use a variety of techniques to assess capability and capacity including:

- Predictive modeling
- Performance monitoring of key system indicators

Predictive modeling techniques forecast 18 months or more of anticipated changes in transaction volume to be able to plan system capacity improvements before the capacity is needed. In the figure below, we see a predicted membership total for the next year and a half on one of our particular platforms. The projection accounts for all sources of known volume growth, from new customers, organic growth and internal system changes. This projection is compared to typical transaction volume on a per-member and per-user basis to identify where the current environment will need capacity improvements, before we actually need them. When projecting transaction volume for Bayou Health we assumed the maximum enrollment level possible today in our predictive model.

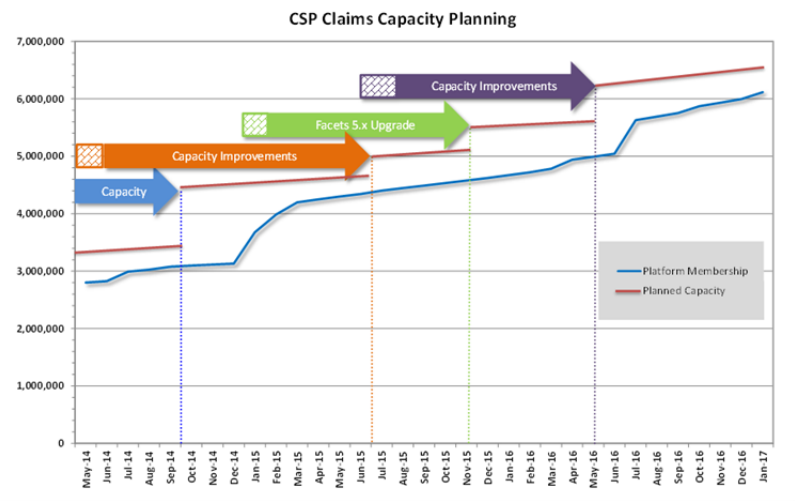


Figure 19. Capacity Planning. We devote significant corporate resources to monitoring capability and capacity and plan infrastructure upgrades and system enhancements to offer the best technology solution possible.

Highlighted on CSP Facets Claims Capacity Planning chart are points where improvements to processing capacity will be needed, and this is used to initiate upgrade projects when needed. Of course, no predictions are perfect, so UnitedHealthcare also proactively monitors both current system capacity and response time to identify and resolve issues when they do arise.

We achieve system consistency, stability and performance through a combination of load balancing software, advanced hardware and virtualization capabilities for our systems. We provide scalability and extensibility in this architecture through the following options:

- Vertical scaling allows the addition of central processing units (CPUs) and disk storage to existing servers so we can increase the capacity of machines already in place
- Horizontal scaling allows the addition of new front-end servers to increase machine footprints

We have the flexibility to add systems capacity in either manner, which allows us to quickly introduce routine upgrades, while giving us the latitude to plan for significant increases in

computing needs without risk or material operational impact. This also provides a level of fault tolerance through use of multiple servers and shared storage, allowing instant recovery from failures in these components.

Deficiencies Discovered

The Auxiliary Database (AuxDB) was found to be low on capacity in a previous capacity review and there is an operational effort underway which has already moved 25 percent of the processing to a new database with ample capacity for growth. This effort will be completed in the Q4 2014.

Recent System Upgrades

A strategic capacity and tuning plan is in place for CSP Facets, which includes an annual program that comprises numerous projects to improve the application and infrastructure. The CSP Facets Phase Three project has delivered 18 application tuning releases and eight infrastructure deployments between March and August 2014.

Upgrades and Enhancements to Existing Systems

While our existing platform provides the capabilities required under the new contract, we believe new technological innovation is vital to optimize performance as programs evolve. Therefore, instead of upgrading our legacy platform, we are implementing the Bayou Health program on our next generation state-of-the-art platform CSP Facets, as described below.

Major System Changes/Enhancements

We are committed to continuous improvement by investing in information systems—people, process and technology—to increase quality and reduce the cost of care for our customers. With that in mind, we are implementing the Bayou Health program on CSP Facets. Our IT team is fully engaged in the implementation of this technology for Bayou Health members and will complete implementation in time for go-live on February 1, 2015.

Planned Infrastructure Upgrades

As part of our ongoing capacity expansion program, the following infrastructure upgrades are planned for 2014:

- CSP Facets Sybase database upgrade
- Reporting database upgrade
- Adding three servers to the new reporting database cluster
- System stress testing
- Index tuning to optimization replication into the new reporting database
- Adding one server to the Web and voice portal application
- First wave of migration of ad-hoc users to the new reporting database
- Claim load pre-processing tuning
- Build out of additional non-production application servers

As we move into 2015, our present projections indicate excess capacity to address the currently known and planned platform growth. From the ongoing capacity monitoring we have identified a need to improve the performance on our provider data interface and plan to do so in 2015. In addition, capacity planning and performance monitoring will continue as described above.

Finally, to maintain support and compliance, we plan to upgrade the most recent version of Facets.

Proven Technology

The state of Louisiana will be our latest state to implement CSP Facets joining Maryland, Washington, Texas, Nebraska, Kansas, Ohio, New Jersey, New York, Wisconsin, Pennsylvania, Delaware, Arizona and Michigan.

As part of a strategic initiative to consolidate claim platforms, efforts began in 2009 to build out the infrastructure and core system configuration for the CSP Facets platform. In August 2011, our first health plan successfully migrated onto CSP Facets. As our business continued to grow, the CSP Facets implementation schedule expanded to include both migrations from our legacy claims platforms as well as new business implementations directly onto CSP Facets. Listed below are the deployment dates for those health plans that have already gone live on CSP Facets.

[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]
		[redacted]	[redacted]
		[redacted]	[redacted]
[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	

UnitedHealth Group's breadth and depth of resources enables us to manage multiple implementations. Through the history of the past several years we have developed deep competencies including platform migrations, business alignment and new growth implementations. We establish separate teams based upon program competencies, allowing us to successfully manage multiple initiatives simultaneously.

The CSP Facets platform has and will continue to be improved to support the contractual needs of our Medicaid and Medicare D-SNP business; to the degree possible, we standardize technology solutions and processes to provide a more streamlined and cost-effective solution for Medicaid and Medicare programs. Through standardizing our technology solutions, we reduce costs, leverage industry standards and improve operations while at the same time accommodating program variations using built-in, repeatable best-of-breed patterns.

- Other efficiencies, benefits and advantages of the CSP Facets platform include the following:
  - Greater simplicity and standardization
  - Greater performance and predictability
  - Fewer issues and rework
  - Comparable metrics across all health plans on the CSP Facets platform
  - Standardized organizational alignment, processes and systems
- Flexibility and scalability:

  - Configure State requirements quickly and economically
  - Implement new programs quickly and economically
  - Leverage common set of enterprise assets, resources
- Reduced costs:
  - Higher auto-adjudication, lower manual processing/adjustment rates
  - Medical cost savings from improved claim editing
  - Leverage a common set of operational and regulatory reports and data extracts

Information technology is a core element of a modernized health care system. It bridges long-standing communications and information-sharing barriers, and creates powerful linkages among all participants in the health care continuum. By adopting coordinated, interoperable technology, providers, payers and members are empowered to obtain and use data to make accurate and efficient decisions, making the health care system work better. As such, UnitedHealthcare devotes significant corporate resources to monitoring capability and capacity and plan infrastructure upgrades and system enhancements to offer the best technology solution possible for our State partners and the members we serve. Here is a summary of our anticipated upgrades during the next 18 months.

Planned System Implementations

As our clinical model continues to evolve, we will implement new technology to ensure we are providing the best care in the most coordinated and efficient way possible. With each system enhancement, our goal is to deploy a solution that integrates disparate technologies and data sources to present interdisciplinary teams with timely, relevant and actionable information about our members and their interactions with the health care system. Here are some of the components presented in our overall architecture that are not currently implemented. For descriptions of the applications, reference the systems capability overview under W.1.

Member

- Health4Me (early 2015)
- *myuhc.com* enhancements including member access to the HRA (early 2015)

Provider

- BayouCloud portal (throughout 2014 and early 2015)

Clinical Services Enhancements

- BayouCare Platform (early 2015)
- Further integration with LaHIE (2015 and throughout the life of the contract)

Operational Technology Enhancements

- Healthplan Manager (early 2015)
- Enhanced linkage between NDB and CAQH (late 2014)

W.3 Describe how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. Your description should encompass information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major systems; and continuous testing of all applicable system functions. (10 points)

Ensuring Systems Availability

Our current infrastructure is completely scalable and able to support significant membership changes and growth. We achieve system consistency, stability and performance through a combination of load balancing software and advanced hardware and virtualization capabilities for our systems allowing both horizontal and vertical scaling patterns. We have sufficient, scalable, enterprise-wide IT resources to handle membership growth including backup servers to handle information increases and system redundancy. Server platforms are scalable and allow for the dynamic reallocation of system resources to different applications as necessary to support demand fluctuations. This scalability enables us to add additional members, provider networks, reporting and care management transactions for DHH quickly and often, without adversely affecting the platform or requiring downtime.

Redundant Data Centers and Failover

UnitedHealth Group's data center facilities (DCF) team manages the Minnesota data centers where our systems and data are located. From Minnesota, the DCF team manages our network operations and strategic network of data center facilities. Within each data center, we implement critical systems with a redundant plus-1 approach where hardware is replicated for a seamless cut over to secondary devices. As presented below, our network of data centers, which meet or exceed all ANSI/TIA 942-Data Center Tier 1-3 standards, significantly mitigates risks from data center disabling events and ensures availability of key production systems and data 24 hours a day, seven days a week.

[redacted]

[redacted]

[redacted]

Business Continuity/Disaster Recovery Strategies

UnitedHealth Group relies on a diverse array of interconnected information systems to meet the needs of our departments and members. The goal of disaster recovery planning is to protect the organization in the event all or key aspects of our operations are rendered unusable, and preparedness is the key. We have instituted an Enterprise Disaster Recovery Program to first eliminate or reduce disaster recovery risk in critical technology areas, and then plans for the facilitation of timely and predictable restoration of key applications, data and supporting critical infrastructure.

Event Management for Effective Business Continuity and Disaster Recovery

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

assistance is available to local teams. Mr. Lirette oversees local business continuity planning and training and works with our national call center that monitors all weather and disasters; they convene emergency calls with affected site and support leaders in potential event areas. The EMT manages the situation and makes critical decisions to drive remediation and coordination with various internal and external stakeholders, as determined by the event type and short- and long-term impact on the organization. They also support execution on event management decisions and provide central coordination of communications, resources, personnel, issues and other information through the notification and response phases of event management.

UnitedHealth Group Business Continuity Planning Benefits

- Ensures continuity of care for our Bayou Health members throughout the State
- Reduces the impact of a catastrophic disruption on the Bayou Health program
- Enables a timely and organized response to a catastrophic disruption and minimizes additional loss
- Facilitates communication between internal and external stakeholders.
- Ensures recovery of all critical services to the affected business functions and provides critical services to customers
- Provides a time-phased restoration of all business resources and services impacted by a catastrophic disruption

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

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

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

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

The EMT consists of the following functional leaders:

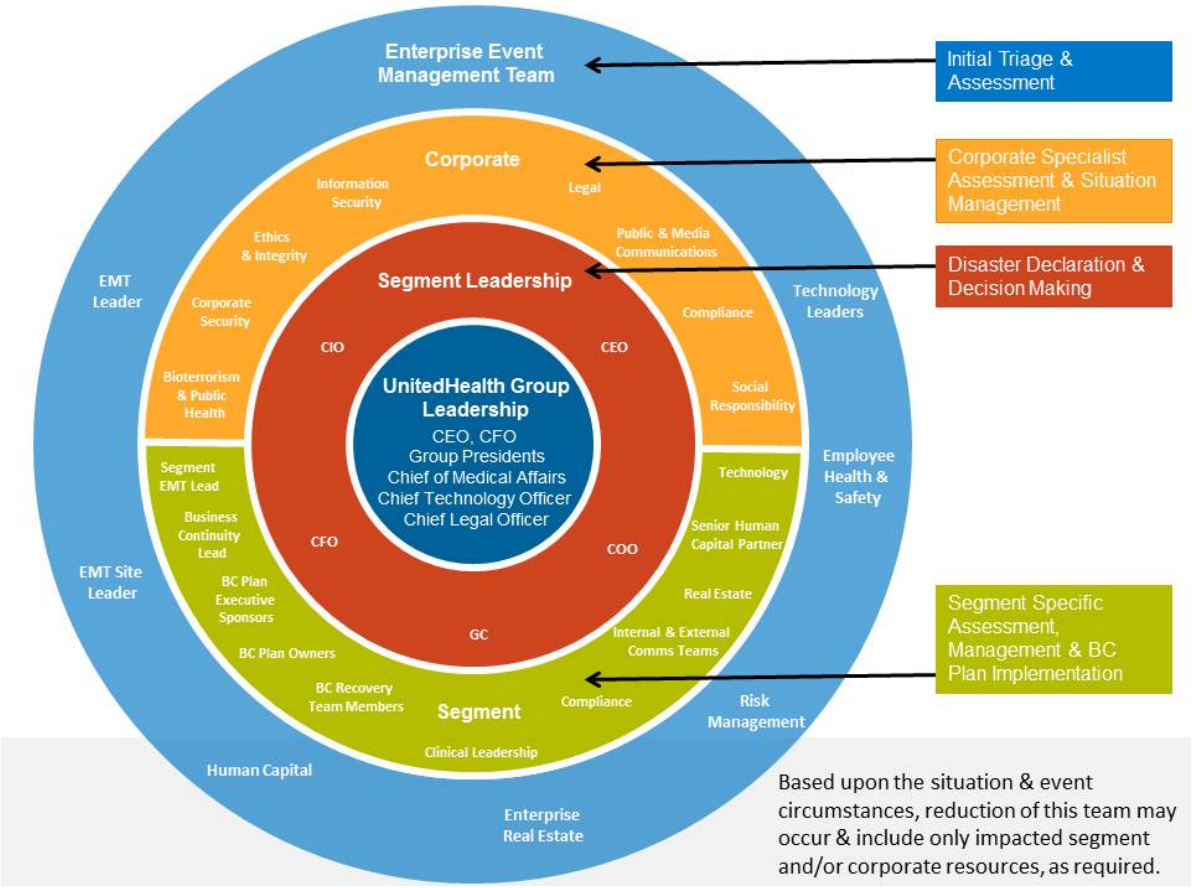


Figure 63. Event Management Leadership. Our program provides structure that facilitates an effective response and recovery when a major event occurs. UnitedHealth Group's approach to disaster recovery is based upon the two fundamentals: prevention and protection. A focus on balancing the combination of disaster prevention and protection results in reducing both the probability and impact of a disaster. The Enterprise Disaster Recovery Program eliminates or reduces disaster recovery risk in critical areas, and then plans for the most probable disaster scenarios.

Prevention

UnitedHealth Group's strategy focuses on items that assist in preventing a disaster from taking down systems in the first place by creating an effective combination of people, process and technology that provides the fundamentals for a proven production method. This results in a stable, scalable environment for our applications to perform at operational excellence and creates the "prevention" that is fundamental to the Enterprise Disaster Recovery Program.

Protection

Completely avoiding a technology disaster is impossible. However, the Enterprise Disaster Recovery Program anticipates and plans for the common types of disasters and designs solutions to address them. Disaster protection addresses recovery from the most probable disaster scenarios to the worst case scenario of a total loss of a data center.

Highlights of the disaster recovery protection components include:

- UnitedHealth Group data centers can operate in a "lights out" mode for up to three days. If the data center continues to get fuel to run the generators, they can run in this mode indefinitely.

- Operational backups use high performance disk-to-disk primary copy with physical off-site second copy tape.
- Disaster recovery Active and Standby solutions employ active-active or active-passive components located in two geographically separate data centers where either site can fully support the production application in the event of a disaster with little to no manual intervention.
- Mainframe storage area network (SAN) replication "rapid recovery" employs full asynchronous data replication between the production host and the geographically dispersed hot standby disaster recovery host.
- Distributed storage area network replication system "rapid recovery" employs full asynchronous data replication of production storage pools and failover of production processing to geographically dispersed non-production processing.
- Some distributed systems employ a hot internal solution with production to geographically separate non-production failover and tape data restore.
- Vendor site recovery agreements with tape restore are purchased for less critical and less integrated applications.
- Each critical application has a disaster recovery plan that is refreshed at least once each year and tested annually.
- Metrics in the form of key performance indicators are used to derive the "health" of the enterprise disaster recovery program.

Business Continuity of Critical Operations

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

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

Upon a disaster declaration for any UnitedHealthcare Group location or system, appropriate BC/DR plans will take effect and applicable disaster recovery teams will be engaged. Should our local offices become inaccessible or disabled, depending on specific circumstances, our affected staff would use other Louisiana offices connected to our internal network with full access to all systems, or staff would access our systems securely from their homes or evacuated location via our internal VPN. In certain cases, we would relocate functions to neighboring states to ensure continuity.

Availability/Recovery Time Objectives by Major Systems

The UnitedHealth Group Information Technology enterprise disaster recovery strategy involves identifying critical business processes and transitioning these critical applications, data and supporting infrastructure to an alternate recovery location in a timely manner, thereby reducing the impact of a technology event to our critical business clients.

UnitedHealth Group uses a variety of recovery strategies which align to the defined criticality of the application. Business critical applications, as defined by the Business Impact Analysis and subsequent Business Continuity Plan, are given the highest priority and generally have a 72-hour or less recovery time objective, meeting the State's recovery requirements. We use highly available infrastructure with automated failover, online and offline backups and geographically separated recovery sites to meet recovery time objectives.

Continuous Testing and Monitoring of System Functions

We use tools, such as AlarmPoint and Hewlett-Packard (HP) OpenView, to continuously test and monitor our systems. AlarmPoint monitors data and automatically generates service manager incidents and automated notification of support staff. HP OpenView monitors systems and networks 24 hours a day, seven days a week by polling key operating system performance and utilization metrics every five minutes and stores the data in log files for analysis. We have defined thresholds for each metric and alerts are generated if the threshold for that metric is violated. HP OpenView is the primary logging and alerting tool that takes alerts, logs and creates service tickets and alerts. Additional monitoring tools include Compuware's Vantage Analyzer (Java & .NET instrumentation), Server Advantage (Websphere and DB2 monitoring), Bradmark Surveillance (Sybase monitoring and Client Advantage (agentless transaction monitoring).

Using these monitoring tools, we can oversee high-priority services, such as:

- Service availability is monitored (e.g., can a user login?).
- Vital business functions are monitored for availability and performance using synthetic transaction monitoring. Synthetic transactions run every five minutes to test that the vital business functions are available and working as designed. All vital business functions have been broken down into their key components/fault domains (e.g., database and mainframe CICS region) and the functionality of each component is tested.
- Key UNIX processes and Windows services are monitored for up/down status.
- Key log files are monitored for exception conditions that require action from support staff.
- Home grown or other non-IT service management standard monitoring tools/solutions have been integrated with HP OpenView operations.

- Key end-user applications have been added to Compuware Client Advantage to capture information about the end-user experience and baseline transaction volume.

AlarmPoint subscriptions provide support personnel with notification when monitors are triggered.

Education and Training on Preparedness for Business Continuity and Disaster Recovery

Mr. Lirette oversees local business continuity planning and training. As part of our training program, all UnitedHealthcare recovery team members are educated on the Business Continuity Plan (BCP), what it covers, and staff responsibilities and expectations; senior managers receive BCP training annually. In turn, they educate other established staff members, providing updated instruction and appropriate preparedness training. Our staff is well trained and highly experienced in "proactive" disaster recovery responses. Recovery team members have multiple opportunities for training, to include:

- Business Continuity Emergency Management LearnSource course
- Business Continuity Plan Development LearnSource course
- Event Management LearnSource course
- Business Continuity Emergency/Plan Development Change - WebEx Forums
- Structured Plan Walk Through
- Business Continuity Annual Exercise
- Event Management Team Site Lead Orientation

Provider and Member Call Center

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

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

UnitedHealth Group is committed to using state-of-the-art technology. Providing excellent customer service remains a top priority for UnitedHealth Group. Receiving and resolving calls from clients is a large and critical part of our business. UnitedHealth Group has implemented a virtual contact center that dynamically routes a million calls daily across 40-plus contact centers and 20,000 service agents. If there is an event at a remote call center, incoming calls can be immediately rerouted to alternate call centers for processing and resolution, reducing any impact to our clients. In the event of a disaster, the call centers have developed and use special procedures for communicating with members and providers, and tracking and recording calls during and after a disaster impacts Louisiana.

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

We identify a specific location as the first-line backup in the event of an emergency or unanticipated increase in volume. That first line team is fully trained in administering the Louisiana business rules, policies and procedures. In addition, they are trained in cultural competence, pronouncing Louisiana names, locations and travel distance. We will continue to operate our member and provider call centers from Houston, where the personnel are well versed in Bayou Health operations. In the event that another work-site takes on the Louisiana workload, that team has access to all the workflows, policies and procedures specific to Louisiana to ensure that members are served seamlessly.

Our member and provider call centers are not stand-alone facilities. Our call and claim operations are performed by trained staff from multiple geographically dispersed locations, and our non-impacted locations are prepared to take on additional work. Our management implements advance travel teams. Individuals on these teams are equipped with laptops and are deployed to an alternate city in advance, to allow us to continue operations without disruption.

Event Communication

The event management team provides a consistent and reliable approach for communication and engagement between all required parties necessary to manage a major event.

The EMT assesses the situation daily with our members and customers and our own operations. BCPs are implemented to minimize impact to operations and a toll-free number is implemented to provide vital information to impacted employees.

Communication with Staff and Suppliers When Normal Systems are Unavailable

Locally, Mr. Lirette manages communications in accordance with our BCPs including leaders in the following roles: customer communication lead, vendor communication lead, segment internal communication lead, media communication lead and regulatory communication lead. Individuals are assigned accountability for these roles and are responsible for developing communications for critical staff and suppliers regarding the impact and remediation efforts for the affected plan.

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

Louisiana Case Study

Our corporate EMT monitors hurricane activity on a daily basis, and can mobilize the appropriate planning and response resources quickly once the storm reaches hurricane status. Some hurricanes spawn very quickly, Hurricane Humberto in 2009 went from a storm to landfall in just 14 hours, fortunately with little damage as it made landfall between Texas and Louisiana. Following is a more recent example.

In August 2012, our EMT began monitoring tropical storm Isaac, which was moving through the U.S. Virgin Islands and expected to continue its northwesterly track. Our EMT began event meetings with business leadership, twice daily, on August 23 to monitor storm impact and make preparations in anticipation of impact to our business sites. By August 26, UnitedHealthcare leadership began readying the business for continuity of operations as tropical storm Isaac was forecast to become hurricane strength impacting southeastern Louisiana. Our leadership activated the UnitedHealthcare Louisiana Emergency Management Plan and subsequent BCP, and began implementation for loss of facility and resource availability due to the evacuations ordered by Louisiana Governor Jindal. Systems availability was not impacted.

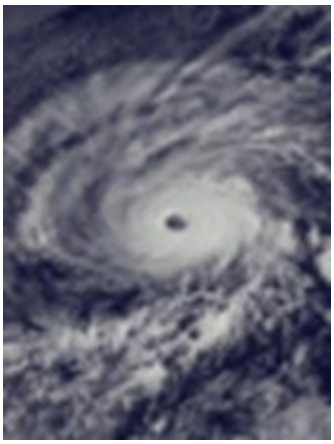


Figure 64. Our BC/DR plans are developed to address all types of disasters, including hurricanes.

Early and ongoing communications by Mr. Lirette to employees, DHH, and the EMT ensured effective preparations. Strategic communication continued to be key to ensuring effective response and recovery throughout the event, which was accomplished by the ongoing outreach of UnitedHealthcare staff from member and provider services, health services, special care needs/associated dependencies groups, medical management teams and executive management. Our key leadership reported into the State emergency operations center in a timely fashion, as requested by DHH.

For the high impact areas, we simultaneously confirmed the health and status of our employees in the region, and implemented measures to provide continuous communication and care for members and providers. Our Louisiana-based provider advocate team implemented call trees, and reached out to our high-volume providers to identify their expected whereabouts during and after the storm. Systematically, our staff worked through the communication grid, contacting all persons on every level involved with care management.

Throughout the crisis, we worked with our provider network and supported our members to ensure continuity of care. We evaluated network capacity in the geographic area, and communicated reassignments to our largest and most critical providers and affected members. Under the direction of our local director of member outreach, our member outreach team notified members and, as appropriate, family members to communicate prior authorization; provider transfer, if necessary; and other applicable instructions. Under the direction of our chief medical officer Dr. Ann Kay Logarbo, we contacted those at-risk members with urgent/emergent and special needs, and arranged for care continuity, while collaborating with local health services agencies. We assisted members with implementing their transition plans of care (i.e., continuity of care) and reminded members to bring their medical ID cards, medical equipment and supplies, and medications in an evacuation. We collaborated with DHH on providing replacement DME and medications when necessary. We also assisted members with transportation needs by working with them to arrange transportation.

Overall, we were successful meeting patient needs and understanding the impact to major physician practices. During and after the hurricane, we maintained our compliance measures with the call center and provided specialized storm call reporting requested by DHH.

W.4 Provide a flow-chart (marked as Chart E) detailing your process for identifying, testing and implementing system changes, to include time frames associated with each step. (5 points)

Process for Identifying, Testing and Implementing System Changes

Our System Delivery Process (SDP) is the structured process we use to build or enhance any system or process with which we receive load and process data from DHH and other key stakeholders or to supply DHH and other key stakeholders with data extracts, including enrollment, encounter and provider files.

As illustrated in the diagram, our process enables us to efficiently manage our extensive network of systems and applications to ensure they continue to meet changing requirements and new functionality, whether internally initiated, requested by DHH, required by federal law or otherwise mandated.

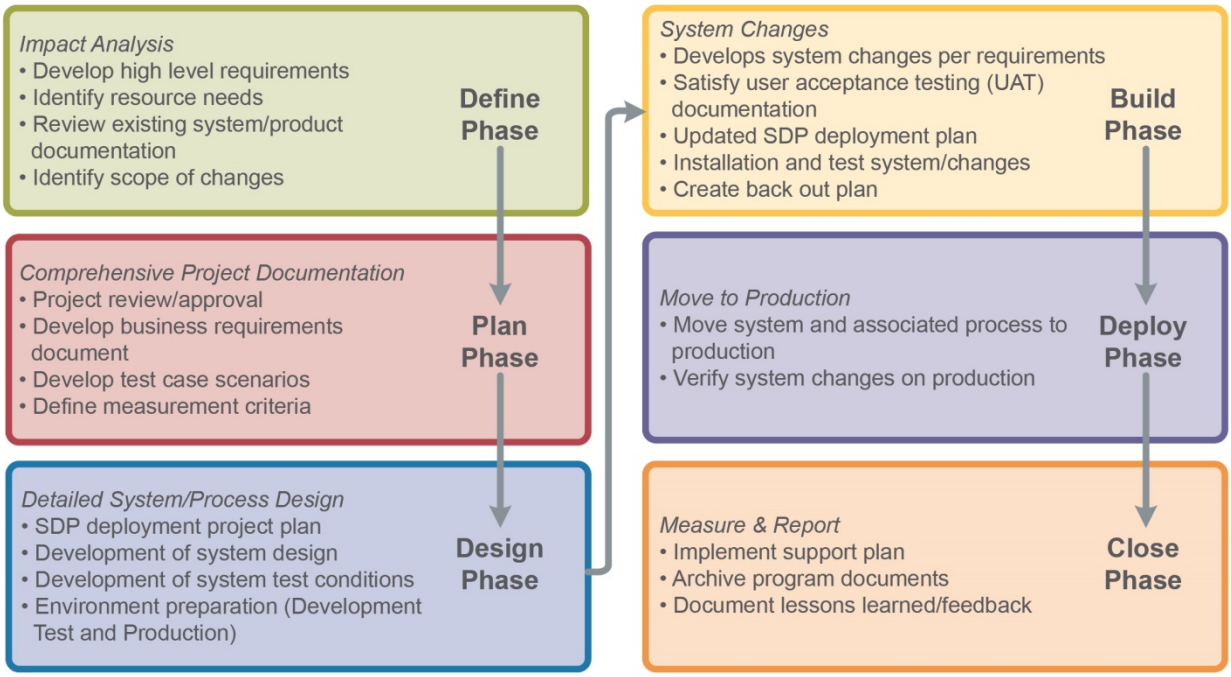


Figure 65. Chart E. Our System Delivery Process, used for identifying, testing and implementing system changes, consists of six phases.

Definitions for each phase and associated timeframes are presented in the table below.

Phase[1]	Description	Timeframe[2]
Define phase	Translates business information into a formal project and includes completion of an impact analysis, development of high-level requirements and identification of resources needed. A review of existing system/product documentation is completed to identify the scope of changes.	Typically a month
Plan phase	Creates comprehensive project documents and plans for project review/approval, including development of a Business Requirements Document, test case scenarios and measurement criteria.	Typically a month

Phase[1]	Description	Timeframe[2]
Design phase	Develops detailed systems and process designs to satisfy requirements, including a SDP deployment project plan, development of system design and system test conditions and environment preparation (such as development, test and production).	Typically a month
Build phase	Develops and tests system changes to ensure all requirements are satisfied, including user acceptance testing documentation, an updated SDP deployment plan and installation and testing of system/changes.	Typically three to four months
Deploy phase	Moves the system/changes and all associated processes to production, including a management information system (MIS) change ticket with back-out plan and completed system testing.	Typically one weekend
Close (Control) phase	Measures and reports results, including implementation of a support plan, finalization and archiving of all documents and development feedback, lessons learned and closure meeting.	Typically two months

[1]Every phase of our process integrates security policy considerations and testing to protect privacy and security.
[2]Timeframes can be escalated for more urgent needs

Systems analysts, business analysts and plan executives, including Mr. Moreno, Mr. Lirette and program integrity officer Larry Smith consider HIPAA regulations, DHH requirements and the impact to users and stakeholders, when reviewing changes, enhancements and upgrades to systems. This process is governed by our Software Change Management Policy and Procedure, which undergoes annual internal audit and SOX reviews.

As we identify externally and internally driven system changes, we use the full support of our local and national resources to remain proactive and responsive to DHH. We partner with DHH to work emerging system changes through our change management process, and throughout implementation of system changes, we continue a high level of engagement with DHH, including:

- Understanding State, federal or otherwise mandated requirements
- Agreement and documentation of the requirements
- Joint test planning
- Go-live planning and coordination
- Cross platform test execution, test case review and testing approval
- Go-live coordination and post go-live monitoring

Aspects of Change Implementation

Our SDP is our disciplined approach for process development, change management and test controls for validity and accuracy. All six phases of our SDP include review steps, approval steps and required approvals. To maintain compliance, a business requirements traceability matrix is developed linking the solution back to the requirements documentation. To confirm all processes are followed as required, we conduct internal and SOX-compliant reviews between phases.

Determining How Changes Impact Other Systems

The process of defining a project starts with requirements – working toward a better understanding of the problem and analyzing and documenting the parameters of success. Well-constructed requirements are concise, unambiguous, measurable, testable and traceable. They

describe what a solution needs to provide – not how the technology should be built to accommodate it, or even if technology should be built.

Requirements development is the process of discovering the business needs based upon value. The process includes eliciting, analyzing, specifying and validating requirements. Requirements development provides a set of measurable business needs that explicitly state how business success is defined. The requirements serve as the basis for design, development and testing of the solution.

Requirements and Solution Analysis (RSA) is our process for defining requirements. It ensures we capture the technology enhancements required by our contracts to ensure we meet contract and customer expectations. It helps us understand the "why" and the "what" before the "how." RSA contributes to a reduction in test-related defects, contributes to a reduction in change controls, identifies unnecessary IT spend before the work is committed and improves IT development estimates.

Requirements and Solution Analysis introduces new development techniques by:

- Explicitly separating business requirements from solutions
- Collaborating between business and technology teams to evaluate solutions against measureable business requirements
- Acknowledging the iterative process between requirements identification and solution analysis
- Performing thorough inspections on project deliverables to improve quality

As part of solution analysis, RSA provides a mechanism to identify the impact of changes in one application on groups, applications and users throughout our managed care information system.

Project requests, system enhancements and system implementations are reviewed and approved by the Louisiana-based chief information officer, with input from other senior leaders and submitted into development. Once the project is approved, it is assigned a project number and manager for tracking, estimation, approval by capital committee and scheduled with assigned resources to support successful completion. A given project may have several sub-projects depending on the complexity and systems impacted.

Testing Phase

The UnitedHealth Group Testing Center of Excellence (TCoE) develops and implements consistent and repeatable QA processes across UnitedHealth Group IT Enterprise applications to identify and remove critical defects before time of release. The TCoE focuses on the following areas of development to instill quality within our applications:

- ***Metrics:*** Defining and implementing common metrics across the QA domain to enable a consistent perspective on quality throughout the organization.
- ***Testing Standards/Best Practices:*** As a core capability of the TCoE, we define the optimum methodologies and approaches for QA in a manner that can adapt to multiple technologies and implementation approaches. We also look to capture and communicate successful approaches that can be better leveraged throughout the organization.
- ***Quality Assurance Training and Development:*** Enhances the capabilities of QA within UnitedHealth Group IT by developing a career map to show the possible paths within the

QA realm, supported by educational opportunities to advance professional and functional knowledge.

- ***Automated Testing:*** To help improve quality while reducing cost, this effort advocates the expansion of automated testing within UnitedHealth Group IT leveraging consistent, advanced frameworks.

Production Control Operations

Our development teams test system changes based upon metrics, standards and methodologies developed by the TCoE. The test environment attempts to reproduce the production environment as closely as possible. However, we physically separate development, test and production environments to reduce the risk of accidental change or unauthorized access to production software and data. The separation of these environments is paramount to ensure software developers do not have access to source code after it is migrated from the development environment and test data are sanitized whenever possible. In the event actual production data are needed in the test environment, only authorized individuals have access to such data, and the data are destroyed when testing is complete.

To determine the scope of the testing, the team evaluates the scope of the change, such as a major system change or a minor change. Based upon the evaluation of the scope of the system change, the team employs system testing that can include cycles, such as unit testing, assembly testing, system testing, regression testing, integration testing, user acceptance testing and consumer centric testing. The security features of new applications, or significant changes to existing applications, are properly tested, documented and reviewed prior to promotion to production.

Application security features and the results of security verification tests are reviewed with information owners and resource administrators prior to application installation and use. Testing of security features and controls is performed as part of application testing. For high-risk systems, such as Internet-facing systems, the software is subjected to an independent security review by IRM. Evidence of security verification tests is documented and includes details regarding who performed the test, the nature of the tests performed and the results of those tests.

Steps to Validate System Configuration

During program pre-implementation and in support of ongoing maintenance of our existing operations, we validate our claims systems and processes to confirm accurate claims payment by performing the following activities:

- Facility and ancillary contract testing verifies the contract configuration based upon contract intent review. Testing includes data integrity report analysis, execution of contract scenario tests with full integration of benefit packages, special processing instructions and production load accuracy verification.
- Fee schedule load is a program that validates data load against source files and produces error reports for review and approval by our manager of claims operations.
- Professional contracts set up provider type templates for comparison against new provider loads to the system and compares reports to verify the new contract fits our templates. The configuration templates reduce the number of potential errors through standardization.

- Claim edits and reimbursement policies test our system configuration against DHH's and our reimbursement policies to validate accurate claims adjudication.
- Benefits and authorization updates test our benefit and authorization system configuration against DHH's and UnitedHealthcare's guidelines. Testing artifacts are produced.
- Metrics and controls report installation accuracy trends and are used for continuous quality improvement.
- Once our claims systems and processes have been validated, our claims team, regardless of the method of claims submission, uses CSP Facets to track and process all claims according to type and in date order. To validate accurate and timely claim adjudication, the claims team:
  - Conducts daily check runs to issue payments and generate remittance advices indicating paid and denied claims.
  - Returns electronic claims to providers who do not pass automated edits prior to loading into CSP Facets and returns an image of paper claims when the member cannot be identified.
  - Generates various reports to monitor timeliness standards and trigger research of aging claims.
  - Conducts operational meetings to determine cause and subsequent remediation of any missed metrics.
  - Engages the Claims Quality Assurance program based upon a set of quantifiable measures and multiple initiatives to monitor our claims processing operation and resolve deficiencies.
  - Conducts audit reviews to examine transactions for specific problems and identify error sources.
  - Conducts post-training certification reviews to check the financial and procedural accuracy of claims processors.

Focused contract audits are used to audit contract terms against facility paid claims on a monthly retrospective basis. We perform claim payment accuracy audits by validating system configuration against the contract terms. The contract audits include a review of the accuracy of the claims paid against the new contract installation to catch errors early in the lifecycle of new contract loads. Defect remediation follows Six Sigma remediation processes and triggers additional audits upon resolution.

Additional audits are performed periodically to ensure codes are set up per our benefit determination and DHH program requirements. We also perform annual audits based upon regulatory requirements, including SOX.

Experience working in Partnership with DHH to Make System Changes

UnitedHealthcare has significant experience working in partnership with DHH to refine our managed care information system to meet new requirements and enhance the support of services delivered to our members. In fact, within the past 12 months we have implemented a number of program changes for DHH. Some recent initiatives include:

- ***UnitedHealthcare EDI Editing Project implemented April 24, 2014:*** We initiated this project to remediate claims discrepancies at the EDI level to produce clean claims in our outbound claim files to Molina, and ultimately produce the cleanest encounters possible.
- ***T-MSIS – Transformed Medicaid Statistical Information System:*** as a CCN-S plan, the State's FI completes our claim processing after our claims pre-processing. To meet the requirements of the national, CMS-driven T-MSIS initiative, our outbound claim files (837s) must include specific HIPAA-compliant data elements that allow Molina to submit T-MSIS data for FFS Medicaid, and on behalf of the CCN-S plans. We worked with the State's FI, creating and submitting test files that allowed them to confirm their processes were in place to implement this CMS deliverable on schedule.
- ***PCP Linkage Report:*** The PCP Linkage Report is a new weekly state requirement implemented in August 2014 to track member/PCP linkages through time, with the goal of evaluating PCPs based upon the claim data of linked members, etc. This is a comprehensive weekly report each, including extensive details of all PCP linkages for all health plan members, both historic and current. This report was successfully implemented and is functioning to meet all requirements.
- ***Prior Authorization Reports:*** We created and transmitted the new, weekly, state-mandated reports of approved and denied authorization requests.
- ***Pharmacy Lock-in Members:*** Accepted specific members who were part of DHH's Pharmacy Lock-in program, flagged them in our system, and began intense case management to make sure their medical needs were met while remaining diligent to their assigned Pharmacy and managing their drug utilization.
- ***Modifier 22 Analysis and Remediation:*** Worked with the State and their FI to review and remediate hundreds of claims pended in the FI's system for supporting documentation, which of course we would have received, not the FI. Reviewed all claims and categorized for FI processing, resolving lingering claims issues for dozens of providers. Implemented system enhancement to flag these types of claims going forward to prevent the delay in the FI's system.

W.5 Provide a flow-chart (marked as Chart F) detailing your process for receiving, processing and updating member enrollment, to include time frames associated with each step. (5 points)

We process electronic data transmissions daily and monthly from Louisiana DHH for Bayou Health members, including the additions, deletions and modifications to the program's enrollment. We have been successfully performing this function in our existing Bayou Health contract and will continue the current process for this contract.

We rely on our Electronic Customer Gateway (ECG) for data/file exchanges. Our ECG service for business-to-business information exchanges provides a secured and security-compliant electronic transport mechanism for internal entities and external business customers to exchange data files, such as 834 (enrollment/eligibility) and 837 (encounters) via scheduled integration with job automation and control services, including transmission validation. The ECG provides:

- Secured transport and non-repudiation of file transfers between UnitedHealthcare and external parties
- Secured file exchange between internal UnitedHealthcare servers using client-base file transfer application

- Activity/audit reporting and UnitedHealthcare information technology security compliance

The ECG uses SFTP, HTTPS and plain FTP with encrypted files transport methods. We coordinate with external partners to ensure valid and complete data exchanges. Access is further limited through the use of firewalls and physical separation of processing systems to mitigate unwanted access.

[redacted]

W.6 Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates. (10 points)

Over the years, we have learned that matching the provider's degree of readiness for HIE to an appropriate technology solution is the key to helping them move along the continuum from basic transactional/look-up capabilities on our provider portal, to becoming an active participant in HIE initiatives. Implementing an integrated eMR with easy-to-use, but effective tools that automate administrative tasks such as eligibility, financial assessment and billing, while enhancing patient care, and can elevate practice operations to a level of meeting meaningful use requirements.

If a provider does not have an eMR system, we offer Optum Physician eMR as a low-cost solution. Optum Physician eMR is our own fully integrated and Meaningful Use 2014-certified,

cloud-based eMR solution. Optum Physician eMR is a simple-to-deploy solution that transforms physician workflow with minimal disruption. The eMR package is fully Meaningful Use Stage 2 2014 Edition-certified as a complete eMR, and represents a best-fit solution for many providers struggling to meet their eMR needs. In fact, more than 12,000 providers have implemented the Optum Physician eMR nationwide as a solution for providing secure one-click access to patient charts, providing lab results from any Internet-connected computer, and enabling integrated electronic prescribing.

We are committed to promoting provider adoption and usage of eMR solutions to all providers, with particular focus on those less able to afford the typically high upfront costs. As such, in Louisiana, we will support providers in obtaining federal grant funds, offer providers zero percent financing through the Optum Bank towards purchase of the Optum Physician eMR software and we will commit up to $500,000 in $4,000 grants to providers towards the purchase of our Optum Physician eMR software.

Promoting Health Information Exchange and Electronic Health Records

We have considerable experience in the adoption of EHR, HIE and Meaningful Use. We are working with Regional Extension Centers (RECs) and Medicaid agencies in many of our states to promote the use of eMR in practices and hospitals, including behavioral health. We are also on many HIE boards across the country and participate in these exchanges. We work with Medicaid agencies to support the deployment of incentives for Meaningful Use achievement. For example in Arizona, at of the end of 2013, approximately 82 percent of physicians in Arizona used an EHR in their daily practice. As of June 2014, approximately $420 million in incentive payments were distributed to more than 10,600 eligible professionals (MDs, DOs, nurse practitioners, physician assistants) and to 250 hospitals for achieving Meaningful Use. In that process we assisted, through the REC, more than 3,000 providers with EHR adoption.

Working in Louisiana we can achieve similar goals by working with DHH, the REC and LaHIE as we did with AHCCCS and others in Arizona. Here are some of the proactive things we have done and can do in Louisiana. Louisiana-based chief information officer will be an active participant and support all efforts of Louisiana Health Care Quality Forum. He will bring experience and lessons learned in other markets to Louisiana and work with the State to continue to transform health care and technology. We can use all of our interaction points (town halls, onboarding, FaxBlast) with providers to promote the adoption of electronic medical records. We will publish educational and promotional materials on the BayouCloud. We will create links to LaHIE Community Health Record and promote an eMR Lite solution with them. We will support getting information out to providers regarding educational opportunities on Meaningful Use and eMR systems. These activities will include:

- Training provider representatives to understand the basics of Meaningful Use and also to help distribute information about free REC, HIE and DHH support services
- Sending fax and email blasts out to Medicaid providers – both regarding REC services and regarding occasional Meaningful Use seminars and educational opportunities.
- Inviting REC, LaHIE and DHH to exhibit at numerous health plan community provider events/fairs to distribute information about EHRs, Meaningful Use, REC services, etc.

As it relates to Meaningful Use Stage 2 requirements we will work with LaHIE and DHH to:

- Provide direct exchange accounts and connect to eHealth Exchange (the national network) that will support our participants in meeting the Stage 2 transitions of care requirements.
- Support the connection through LaHIE to collect Meaningful Use Stage 2 public health reporting requirements.
- Provide our BayouCloud technology to enable HISP/DIRECT secure CCD exchange
- Provide our Automated Care Transitions tool (*UHCTransitions*) to providers for use in care transitions

We have also worked with states, such as Tennessee, to create a common provider infrastructure that can become part of their MMIS platform and therefore be eligible to receive significant funding match from CMS. The promotion and use of common collaborative care transition and care coordination tools is helpful to provider adoption, particularly as you link the services of behavioral and physical health clinics. Referral management is a critical component in reducing the costs of care and thus shared enablement is important.

In Arizona we were instrumental in driving a common statewide HIE led by payers and hospitals. In Tennessee we are working with TennCare and two other health plans on a collaborative shared accountable care platform for their PCMH initiative in which all providers can share a suite common technology. We would be willing to do the same in Louisiana with DHH and other health plans. We would bring best practices from our learnings in Arizona and Tennessee.

Ability to Support "Meaningful Use" of Electronic Health Records

UnitedHealthcare is at the leading edge of supporting Meaningful Use and CMS' 17 core and six menu objectives comprising Stage 2. We are providing collaborative care applications to facilitate the achievement of Meaningful Use Stage 2. These applications will be available to providers for collaboration on high risk members – predominantly BayouCloud, BayouCare and our Population Registry. The following table shows, for key objectives, how our solutions will support Louisiana in achieving Meaningful Use Stage 2:

Core Objectives	How We Can Help	Supporting Technology
Record Demographics	To support 80 percent of unique patients having structured demographics captured, all practices can access and reference member demographics through BayouCloud.	BayouCloud
Use Clinical Decision Support	To support identification of the five clinical interventions required and enable engaging the patient when it can most positively impact their care, BayouCloud and BayouCare enables the provider access to the patients plan of care which will support alignment of clinical problems, goals and interventions with the required five clinical support rules in the provider EHR. The Population Registry can also be leveraged to view high-risk cohorts that support clinical decisions. The provider will have access to directly update or comment on the plan of care to align the patients care.	BayouCare Population Registry

Core Objectives	How We Can Help	Supporting Technology
Provide patients the ability to view online, download and transmit their health information	To support patient use of provider health information, the interdisciplinary care team can be electronically notified and trained to assist the member in access and, more importantly, effective use of online data supplied by their providers. This will ultimately help providers exceed the 5 percent threshold.	BayouCare
Provide clinical summaries for patients for each office visit	To support members receiving a clinical summary within a day of their office visit, clinical summaries can be shared electronically with the interdisciplinary care team for high-risk members and associated with the member's record in BayouCare for long-term reference.	BayouCare
Perform medication reconciliation	To support medication reconciliation for more than 50 percent of members with transitions in care to the provider, the Population Registry and BayouCare can be leveraged as additional external sources to validate medication history.	BayouCare Population Registry *UHCTransitions*
Provide summary care record for each transition of care or referral	To support a robust C-CDA for transitions of care and referrals, including use of eHealth Exchange standards, for high-risk members BayouCare can (a) be referenced in building a summary of care record and (b) used to send a DIRECT message containing the C-CDA.	BayouCare *UHCTransitions*
Use secure electronic messaging to communicate with patients	To support 5 percent of unique patients receiving or sending an electronic message to their provider, the BayouCare platform will be enhanced during 2015 to enable members to send DIRECT messages aligned with CEHRT standards.	BayouCare

Menu Objectives	How We Can Help	Supporting Technology
Record electronic notes in patient records	To support and enrich progress notes in the EHR for the required 30 percent of patients, a summary note from BayouCare can be sent to the provider using DIRECT for high-risk members. This will provide a more meaningful note and starting point for the provider in tracking progress.	BayouCare
Imaging results accessible through CEHRT	To support 10 percent of tests that result in an image being shared, both BayouCloud and BayouCare support transferring of images to the physician via Secure Messaging.	BayouCloud BayouCare
Record patient family health history	To support generating a family health history of 20 percent of unique patients seen, BayouCare can be referenced by the provider to support gathering of health history information as assessed by the interdisciplinary care teams for high risk members.	BayouCare

Addressing Federal Mandates (Current and Future)

When the Patient Protection and Affordable Care Act (PPACA) became law on March 23, 2010, we entered a new era of comprehensive health reform. As an organization that funds and manages care for more than 85 million people, UnitedHealth Group understands the vital role technology plays in improving patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita costs of health care.

Our core strengths are in care management, health information and technology. As America's most diversified health and wellbeing company, we not only serve many of the country's most respected employers, we are also the nation's largest Medicare health plan – serving one in five seniors nationwide – and the largest Medicaid health plan, supporting more than 4.8 million members in underserved communities in 23 states.

We fully anticipate PPACA to continue to drive changes across the U.S. health care system and our program delivery platforms. We are fully committed and will continue to use internal and external resources to develop innovative approaches to improving health care and comply with regulatory mandates. Our systems are integrated and scalable to accommodate current and future state and CMS mandates such as those resulting from the PPACA, meaningful use standards, 5010 standards or ICD-10 code sets.

Local Experience and Initiatives

Louisiana Health Information Exchange

LOUISIANA HEALTH INFORMATION EXCHANGE

We are the only Bayou Health contractor with an active contract with the Louisiana Health Care Quality Forum (LHCQF), the entity that built and supports Louisiana's health information exchange, known as LaHIE. As of August 21, we are live and receiving data nightly from 44 hospitals participating with LaHIE to populate our population registry. In addition, we have direct arrangements with an additional eight hospitals to receive direct nightly data feeds that also populate our population registry. With the LaHIE data feed, the New Orleans Health Connection data feed and direct hospital data feeds now updating our Population Registry daily, we have been capitalizing on this incredible opportunity to improve care transitions for our patients in Louisiana.

As of September 19, 2014, 18 practices are in our ACC program that uses the Population Registry (representing more than 56,500 members). These practices are connected with our ACC team in Louisiana who work collaboratively with them to transform their practices into ACCs. Our team focuses on access, care transitions (ER and inpatient), gaps in care for routine preventive care and chronic condition care and high-risk patient management. The UnitedHealthcare team is imbedded in the practice and works side by side with the practice on a weekly basis.

We also have an arrangement with LaHIE where we have worked with their consultants to train and provide access to our population registry. We partnered them with our ACC staff in Louisiana and we "trained-the-trainer." LaHIE was then able to work with additional practices in Louisiana to help them effectively use the Population Registry in transforming their practices. To date the LHCQF has trained and engaged 12 practices statewide in this project.

With the implementation of this contract, we will extend access to our Population Registry to all contracted PCPs in Louisiana with more than 100 UnitedHealthcare members. Our ACC team

will provide training through group training sessions in person and via webinars across the State. In addition, they provide telephonic support as needed to assist the practices in effectively using the tools and transforming their practices. We currently have six ACC team members in Louisiana in our program that has been live since 2012. This team consists of two fully dedicated employees for each of the three GSAs. Each team of two consists of a community nurse (a RN) partnered with a transformation consultant.

We currently receive ADT information from LaHIE and share it with our providers through our interactive Population Registry tool to improve hospital transitions, assist providers with coordination and continuity of care, and improve health outcomes for our members who transition between care settings, e.g., go to the ER, admitted for an inpatient stay or discharged from a facility. These notifications and alerts improve the timely flow of information so that providers and case managers can quickly and effectively address the health care needs of members transitioning from inpatient facilities to care in the community.

The Institute of Medicine Report, Crossing the Quality Chasm: A New Health System for the 21st Century, identified health information technology as a means of supporting care management and quality of care. Electronic health records and health information technology have great potential to assist with continuity of care. As stated on LHCQF's website, information technology's "next step involves the ability to securely exchange health information within and across states for the purpose of promoting continuity of patient care." We appreciate LaHIE's future capability as a potential vehicle for timely and accurate information transfer for members transitioning to a new MCO, delivery system or program.

In several other states, we have secured participation agreements with exchanges to use HIE data for treatment use. The uses of referral data are highly effective at managing care across the continuum. The ability to schedule referral appointments, confirm the dates and share care continuity documents, e.g., progress notes between specialists and primary care, enhances care navigation and completeness. We have worked with other HIEs nationally to establish MCO data sharing policies, practices and use cases for improving care coordination using EHR exchange between practices, the HIE and the health plans. Laying the right foundation for data exchange elements is essential to care coordination. Having an effective and well-thought out data acquisition strategy from hospitals and clinics is critical to establishing care coordination in the community.

Greater New Orleans Health Connection

Early in 2014, UnitedHealthcare engaged with the Greater New Orleans Health Connection program in Orleans, Jefferson, St. Bernard and Plaquemines parishes to establish basic HIE data for eligibility and hospital and clinic ADT transactions. By using our Population Registry, we can bring ADT data from local participating hospitals and clinics; risk stratify practice population; and provide member-specific evidence-based gaps in care to each practice-attributed panel. The daily data feed of adverse events (hospital/ER) facilitates outreach to members using the ER as a source of primary care. We also offer an Automated Care Transitions tool to help ensure 7-day follow-up with providers post ER or inpatient discharge. These tools are helping us achieve the goal of reducing ER utilization and decreasing hospital readmission.

National Experience and Initiatives

Nationally, we have considerable expertise in the implementation of HIT and even more in making this technology actionable for health homes and ACCs. We are a nationwide leader in EHR and HIE systems. We use our advanced analytics and evidence-based tools to integrate EHRs with administrative data and deliver it back to the point-of-service for action by clinicians. As HIT evolves, it is important to integrate clinical and administrative (claims) data into common repositories to have complete patient profiles for case management. We connect hospital and claims data into an actionable practice-based Population Registry for PCMH and health home use. As of August 2014, our experience spans 19 states, 150 practices, 1,500 PCP sites and more than 500,000 members enrolled in our Medicaid ACC program that uses our Population Registry, plus an additional 730 practices serving 315,000 members for whom we provide our Population Registry technology.

Support for Practice-Based Accountable Care Community Model

We encourage our members to join ACC primary care practices, where staff coordinate care, make referrals to all covered and carved-out services, follow up with members and measure health outcomes. ACC providers have access to our Population Registry as well as our BayouCare clinical platform, which is designed to share member-specific information electronically with the member's interdisciplinary care team. **We currently have 18 Louisiana ACC practices with more than 56,500 Bayou Health members.**

Accountable Care Communities

Louisiana ACC practices have now grown to 17, consisting of more than 46,000 members across the State. Transitioning new or existing members to ACCs helps us achieve Triple Aim of better health outcomes, improving the care experience and lower costs of care for Bayou Health members.

To support full integration of health care delivery in our ACC model, we propose the following capabilities: BayouCare platform and Population Registry (with Automated Care Transitions tool). We are deploying our advanced technology solutions in other markets and are ready and willing to offer structure and expertise with these solutions to the State and to other MCOs to enable and facilitate data sharing.

BayouCare Platform

Our BayouCare Platform supports community-based collaborative person-centered, integrated care for members. It is a HIPAA-compliant, secure, cloud-based health care record and information sharing system that provides comprehensive supports for the continuum of integrated, person-centered care management. BayouCare provides the mechanism to share the critical, relevant and timely member information essential to conducting ongoing care planning, management and coordination across a continuum of services and settings. BayouCare seeks to redress health disparities by providing real-time coordination of member care among multiple providers in different physical and behavioral care settings (e.g., social and family support for the specific populations).

It enables clinicians to develop and share plans of care and co-manage high-risk patients requiring multiple specialists and caregivers. It supports care team collaboration by sharing care continuity documents and progress notes though HISP/DIRECT secure messaging linked to EHR. It also supports a multiplicity of assessments that trigger care events in the plan of care and facilitates alerts to other members of the care team. BayouCare integrates evidence-based medicine gaps in care and hospital ADT messaging.

Shared Integrated Plan of Care

BayouCare's person-centric, shared, dynamic, coordinated, interdisciplinary plan of care provides a comprehensive view of the relevant issues and care needs to support the member's optimal health and achievement of health care goals. All interdisciplinary care team members caring for the member in the community—including physical, behavioral and dental health providers have access to the member's plan of care and can add, change or update issues, interventions and status in the plan of care thereby providing timely and thorough communication for the whole team. Using BayouCare and structured clinical care coordination processes, the interdisciplinary care team can conduct assessments of a member's needs and by applying measureable, evidence-based best practices, the team can create, review and contribute to the plan of care that meets those needs.

BayouCare tracks a member's care preferences, prioritized health concerns, issues, intervention strategies, self-sufficiency goals, how well the member understands and is adhering to the goals and progress assessments. It contains member and integrated care team contact information and maintains each member's condition list, medications, service dates and outcomes, history, provider visits, diagnoses, issues, progress notes and case conference notes, lab results, gaps in care and medication adherence.

It supports ongoing care planning, management and coordination across a continuum of services and settings, and supports collaboration among the interdisciplinary care team by monitoring, tracking and securely exchanging all member health care engagements, care needs, preferences and documentation. The interdisciplinary care team can track the member's progress against the plan of care using several key features, such as an audit log highlighting updates and changes to the plan of care, filtering by particular domains (e.g., mental health), alerting based upon updates or changes and member input.

Accountable Care Population Registry (including Automated Care Transitions)

For our members in ACCs, we provide a daily data feed to participating practices listing members newly discharged from an inpatient stay; notification will occur via our Population Registry and other direct-connect capabilities through LaHIE connectivity.

Our Population Registry and Automated Care Transitions tool is a secure Web-based application providing retrospective and real-time clinical views to partner practices. The Population Registry and Automated Care Transitions tool provide a comprehensive view of the last three years of clinical history on the assigned member population based upon claims. The *member view* within the Population Registry gives providers a complete view of the clinical history of the whole person. The *population view* provides lists of members in the practice who need specific follow-up, integrating processes and scripts for specific steps.

A practice-assigned care coordinator, medical assistant or scheduler uses this suite of tools (Discharge Management, Emergency Visit Management, High Risk Cohorts and Preventive Care lists) for outreach to members and schedule a return visit to a PCP. We then work with our partner practices to set measureable goals for coordinated care. This improves frequency of member follow up, increases the percentage of members with continuity of medication use, following evidenced-based guidelines and decreases the percentage of members in crisis with emergency visits.

We pair the outcomes reflected in the Population Registry with monthly reporting of provider performance. In conjunction with provider services representatives, our practice care managers meet with providers to help enhance provider capacity and close gaps in care measured by evidence-based medicine.

We then hold regular Joint Operating Committee meetings with the practice and local leadership teams to review outcomes against goals, learn from successes and failures and make adjustments to our approach and goals for the next period.

With the implementation of this contract, we will provide access to the Population Registry to all PCPs with at least 100 UnitedHealthcare Bayou Health members.

BayouCloud Portal

The BayouCloud Portal is the next evolution of our online tools, where new features and functions will be added. This cloud-based solution is the cornerstone of our goal to provide a single provider platform to bring together multiple websites and both administrative and clinical applications to simplify transactions. With access to the BayouCloud 24 hours a day, seven days a week, provider offices conduct business with us when it is convenient for them. The features available now through the BayouCloud or to be implemented over the life of the contract include:

Administrative

- ***Eligibility and Benefits:*** Our cloud users can search for UnitedHealthcare-managed members (including our Bayou Health members) to find demographic, eligibility and benefit details.
- ***Claims Management:*** Includes claims search detail (payment/check info, edits, codes and line level payment), clean claim status remark codes, and additional reporting features to assist in account reconciliation. Provider offices will manage their accounts receivable with greater ease due to more detailed information being provided.
- ***Claims Reconsiderations:*** Registered users of the Cloud can submit claim reconsiderations with attachments and can view the status of each reconsideration submission.

Clinical

- ***Enhanced Online Authorizations:*** Allows providers to submit attachments for prior-authorization requests.
- ***Clinical Portal:*** The ability to link our Integrated Care Model tools into a single platform with single sign-on capabilities with the Population Registry, BayouCare platform and Automated Care Transitions.
- ***Electronic Health Record (EHR) Data Sharing:*** Share clinical information from provider's EHR through secure messaging. We will coordinate with LaHIE and the DHH on the use of a common Provider Directory and Master Patient Index
- ***Community Clinical Health Record:*** Working with LaHIE we will seek to make available to providers the HIE community health application with single sign on access so it is available in a common clinical portal for ease of access.
- ***Telemedicine eConsult:*** Enables PCPs to consult remotely and conveniently with specialists to improve health outcomes for members. This tool has successfully increased

access to specialty care and reduced the need for face-to-face office visits by facilitating efficient and secure exchange of health information, and providing increased access to specialists.

- ***Community Collaboration:*** The ability to create online communities of providers and care givers across the continuum of care in a secure messaging environment using secure chat, secure webinars and secure messaging.
- ***Proprietary Systems:*** Various UnitedHealthcare portals, including single sign-on for BayouCloud, for access to administrative functions, prior authorizations, and reporting, including EPSDT compliance reporting.

One of the exciting capabilities of the Cloud technology allows providers to submit attachments of required clinical documentation for prior authorizations. It also confirms that clinical information has successfully been attached to the request once the clinical information is uploaded by the provider. The Cloud portal is integrated with the same CSP Facets platform and systems as our portals and member advocate tools, so any stakeholder involved, whether it is the provider, prior authorization personnel, consumer, member advocate or our clinical team, can have visibility into the status of a case.

All attachments from the provider are posted directly into our document management application with an appropriate case identifier used internally to manage the member. A task indicates to the prior authorization team that the information is available for review in the document management application.

Using the BayouCloud secure messaging capability, providers and UnitedHealthcare staff will have the ability to communicate electronically and exchange information/documents with minimal delay and back-and-forth conversation in an easy-to-use format with a one-click view. The Cloud date/time stamps and tracks when a message is sent and when a message is opened and reviewed by the receiving person. It alerts our user when an electronic message has not been opened and reviewed by the provider within a certain timeframe, so we can initiate proactive outreach.

National Experience

Over the years, UnitedHealthcare has collaboratively worked with numerous governmental agencies/departments on HIE projects; in addition to the work in Louisiana described above, a few examples are provided below:

- ***Florida:*** We have worked with the Florida Center for Health Information and Policy Analysis (FCHIPA) helping to guide eMR and HIE policy and deployment. For example, we participated in Agency quarterly meetings that updated stakeholders on the status of the Florida HIE, we reviewed Agency documentation regarding the Florida HIE and, through the Florida Association of Health Plans (FAHP), we provided comments on the State's plans for the Florida HIE.
- ***Arizona:*** We were key partners in the development of the HIT plan Arizona proposed to the Office of the National Coordinator for Health Information Technology (ONC) for grant funding. We assisted the ONC Regional Extension Centers in meaningful use and provider eMR adoption through these incentives and low cost tools. We developed HIE participation agreements attractive to all community stakeholders to gain acceptance and legislative actions that resulted in opt-out privacy laws; and launched HINAZ.

- ***Delaware:*** We collaboratively worked with the State of Delaware to establish basic HIE data for eligibility and hospital ADT transactions, to pilot ADT use in our clinical services operations. To simplify the interactions between Delaware Health Information Network (DHIN) and the other MCOs and reduce overall implementation costs for Delaware, we suggested and DMMA approved using the Division of Medicaid and Medical Assistance (DMMA) as a common source of eligibility records for all participating Medicaid MCOs. This greatly simplified DHIN's task to populate their master patient index and improved the delivery timeline across all MCOs.
- ***Maryland:*** UnitedHealthcare is participating in a pilot with the Chesapeake Regional Information System for our Patients (CRISP), Maryland's state designated HIE. CRISP is a not-for-profit membership organization that became operational in September 2010 and serves members in Maryland and the District of Columbia. The pilot focuses on making use of ADT information for at risk members using CRISP's Encounter Notification System (ENS) and Portal Query process.

  Presently, these systems are being piloted to identify potential care coordination opportunities. Our teams receive ADT data daily for the Maryland membership test files provided to CRISP. Additionally, they can access clinical records for the patients through the CRISP Portal Query Website. The goal is to improve case management services and acute care setting utilization. Efforts are still underway to assess the benefits and determine if this will be migrated to production in 2015.

As a result of these initiatives in various markets, we have found it is critical that hospitals enter the admitting diagnosis on the ADT transaction and include admission transactions for same day ER visits that do not result in admission. Without these two pieces of information we are less able to realize value in utilization management, case management, medical homes and ED diversion programs.

W.7 Describe your plans to utilize ICD-10. (5 points)

UnitedHealthcare's Plans for Using ICD-10

Code sets are one of the fundamental elements of UnitedHealth Group business. In both physician and payer settings, the ICD-10 transition represents a major impact to all business and technology areas that use medical codes. To frame the scope of the transition, in ICD-9 there are approximately 18,000 diagnosis and procedure codes in use. In ICD-10, there will be over 141,000– nearly eight times more than ICD-9. In addition, ICD-10 is fundamentally different in terms of structure and specificity. ICD-10 uses an alpha-numeric structure that offers significantly more granularity about a patient's medical condition and inpatient hospital procedures. As examples:

- ICD-10-CM provides 50 different codes for "complications of foreign body accidentally left in body following a procedure," compared to only one code in ICD-9-CM.
- ICD-10-PCS provides dozens of combinations of codes for coronary artery bypass grafts compared to only 7 codes in ICD-9-CM.

In addition to compliance of a federal mandate, ICD-10 codes will provide greater detail and increased specificity. UnitedHealthcare plans to use ICD-10 to promote:

- Improved payment accuracy
- Fewer rejected claims
- Improved disease management
- Significant decrease in rework/administrative expenses
- Comprehensive reporting of quality data
- Data tracking of disease: USA/international
- More effective care management and wellness programs

Globally there will be improved disease management and coordination of disease monitoring and reporting. ICD-10 also supports value-based purchasing and Medicare's anti-fraud and abuse activities with accurate service definition and specific diagnosis and treatment information. ICD-10 will allow us to better serve our partners and their customers through greater understanding of illness, morbidity and therefore development of prevention and quality improvement programs.

UnitedHealth Group is working closely with the provider community nationwide, as well as with software vendors and clearinghouses to prepare for ICD-10. At UnitedHealth Group, ICD-10 is more than government compliance. ICD-10 is an opportunity to better serve our customers through seamless, real-time health care management. Faster, more sophisticated, and more predictable administrative transactions enable doctors and hospitals to spend more time caring for patients and helping people live healthier lives. The platform and its interfaces have been updated for the increases in field and data type changes, and indicators and logic added to be able to identify and manage both ICD-9 and ICD-10 based transactions. Payment rules and fee schedules have been translated and continue to undergo refinement.

Our goal is to ensure the ICD-10 implementation has no negative impact to either UnitedHealth Group or our members and business partners. To help ease the transition to ICD-10 across our platform and manage the period when we must manage both code sets, UnitedHealth Group created reference tables and common utilities to crosswalk and map between ICD-9 and ICD-10 codes. Where there are multiple translation alternatives, some translations require selection of a best alternative. The transition has been managed with an eye toward maintaining revenue neutrality, keeping operational stability, and revenue and payments predictable.

While much work has already been completed, we continue to perform integration testing with external entities to ensure a smooth ICD-10 transition by the CMS mandate of October 1, 2015. In Louisiana, we have been working with DHH and its FI, Molina, to support the transition to ICD-10. We participate in the TMSIS meetings and will continue to dedicate the resources necessary to support this process. We are committed to making this a successful transition for all Louisiana stakeholders.

Section X: Claims Management

X.1 Describe system capabilities and limitations of all requirements stated in Section 17.8 Encounter Data, and identify areas where change would be necessary based on requirements stated in the Systems Companion Guide.

Identify any limitations or disparities to requirements stated in Section 17.2, 17.8, and 17.10.

Describe system capabilities and limitations of all requirements stated in Section 17.10 Pharmacy Claims Processing and the NCPDP Guide located in the Systems Companion Guide.

If you presently unable to meet a particular requirement contained in Section 17, identify the applicable requirement and discuss the effort and time you will need to meet said requirement. (10 points)

- We make significant investments in the use of advanced technology to accurately process and pay claims in a timely manner. Our claims management systems are HIPAA compliant and optimize the exchange of information within such key areas as eligibility, enrollment, benefits configuration and reporting. Our use of technology provides an end-to-end approach to both claims and encounters and is supported by a Louisiana-based team led by chief operating officer Karl Lirette. Our claims management and encounter process offers DHH:
  - National experience
  - Best practices based on processing over 15 million claims for 4.8 million members in 23 states
  - National recognition by the American Medical Association as the Number 1 Insurer in the country for claims processing accuracy
- Accurate and timely submission
  - Specialized Medicaid encounter system, National Encounter Management Information System (NEMIS), to ensure accurate and timely encounter submissions
  - Multiple checkpoints and quality reviews to ensure data accuracy of both claims and encounters submissions and reports
- Local Presence
  - Claims and grievance and appeal staff based in Louisiana
  - Locally based management team – claims administrator Angela Warren and our new encounter data quality coordinator
  - As part of our commitment to bring resources to Louisiana, we will move our claims and provider service operations to the State.

Our systems comply with Section 17.2, 17.8 and 17.10 as well as the Systems Companion Guide with **no known limitations or discrepancies**.

Recognizing the importance of accuracy, we are deploying our next generation of Risotto Facets technology – Facets Community Strategic Platform (CSP Facets) – which is vital to optimize performance as the Bayou Health program evolves. CSP Facets is the heart of our system architecture with interfaces that optimize the exchange of information to other key systems, such as the NEMIS, our encounter data submission system.

System Capabilities Meet All Section17.8 Encounter Requirements

Our technology, processes and procedures meet all requirements specified in each Section of 17.0 Claims Management.

Under the leadership of Mr. Lirette, locally based claims administrator Angela Warren and our national encounter business team we have thoroughly reviewed all of the requirements in Sections 17.8 Encounter Data and the Systems Companion Guide and have not identified any limitations to meeting all of the stated requirements. We specifically describe system capabilities of the requirements stated in Section 17.8 per the instructions in Appendix KK.

Leverage Our Success in Similar Markets and in Louisiana

We are excited about the opportunity to continue to serve the State's Medicaid recipients by expanding the scope of our services under this RFP for the Bayou Health program. Our committment to providing accurate, timely and complete encounter data submissions is exemplified in many similar Medicaid state contracts we currently support. As a part of UnitedHealth Group, we benefit from the knowledge, expertise and best practices of our other markets.

Encounters Management Information Systems

We use NEMIS throughout the end-to-end encounters process; from submission and tracking to error corrections and resubmission. The NEMIS infrastructure is equipped with a centralized repository to store and submit encounter submission data in various formats to DHH's fiscal intermediary (FI), as required. Although Medicaid encounter submission, tracking and reconciliation are the primary functions of the system, NEMIS supports most X12 formats (837I/P/D, NCPDP), Medicare RAPS format and proprietary layouts. It is also flexible enough to accommodate any future changes as required by DHH.

[redacted]

NEMIS is designed to accommodate multiple data sources. Claims data from contracted vendors is loaded on a monthly basis into NEMIS. To ensure timeliness of data collections, vendor transmissions (pharmacy and vision) are scheduled and monitored by our media tracker database.

NEMIS also provides our encounter business team and local health plan with reports necessary to track encounter submittal success rates, investigate and correct submittal errors, and make business decisions regarding the processes involved.

An additional byproduct of this system is that as the analysis for a centralized encounters system is performed, a knowledgebase is created that can be used to compare encounters processing practices across states and offer opportunities for improved accuracy and efficiency of claims and encounter processing.

Receiving and Transmitting Encounter Data (17.8.1)

Our encounter system, NEMIS, is able to transmit to and receive encounter data from DHH's FI. We have extensive local and national experience submitting and receiving all encounters in standard HIPAA transaction formats as required by DHH including, but not limited to 837P (professional claims) and 837I (institutional claims), 270/271U, NCPDP, and 278 file formats for electronic transactions. We comply with CMS and HIPAA standards for electronic submission, security and privacy, and we verify our subcontractors adhere to these standards as well.

Unique Processor Control Number or Group Number (17.8.2)

We will create a unique processor control number (PCN) or group number for Louisiana Medicaid. As part of the submission process, we will include the PCN or group number and the bank identification number with encounter claims data.

Encounter Data Submission (17.8.3)

We will submit complete encounter data at least monthly. Our encounter team verifies the timeliness, completeness and accuracy of submitted encounters and continuously improves our processes by:

- Measuring our claim and paid dollar submission and acceptance rates
- Ensuring we include encounters with zero dollar amounts ($0.00) and denials
- Reviewing capitated provider submissions for completeness
- Monitoring error counts by reason for each submission
- Addressing errors or rejects with urgency and prompt remediation
- Reviewing pre-edit processor reports and denied encounter reports to determine trends and root causes
- Developing and implementing source solutions to permanently prevent the future occurrence of previously identified errors

The encounter team works with our IT team to confirm NEMIS is configured appropriately to meet the requirements set forth by DHH such as configuration of denial codes to identify repairable versus non-repairable encounters, validation of encounters against national code sets, assurance of required data elements, and compliance with DHH edits and reimbursement methodologies.

We will submit encounter data no later than the 25th calendar day of the month following the month in which they were processed (paid or denied), including encounters reflecting a zero dollar amount ($0.00) and encounters in which we have a capitated arrangement with a provider. We understand that if we fail to submit complete encounter data, as measured by a comparison of encounters to cash disbursements within a 5 percent error threshold (at least 95 percent complete), we may be penalized as outlined in Section 20.

Working with DHH's Fiscal Intermediary (17.8.4, 17.8.5 and 17.8.6)

Our encounter data collection and submission process confirms all data provided to DHH's FI has first been tested for accuracy, completeness, logic and consistency. We understand DHH's current FI accepts encounters at a document level, with the exception of pharmacy encounters, which are accepted at a line level. We will transmit encounter data to the FI in this manner within 60 days after the contract start date. We plan to conduct extensive end-to-end testing prior to the operational start date.

Using NEMIS, we will be prepared to submit encounter data to the FI in a provider-to-payer-to-payer coordination of benefits (COB) format within 60 days of the contract start date. We understand we must incur all costs associated with certifying HIPAA transaction readiness through EDIFECS prior to submitting encounter data to the FI. We are familiar with the EDIFECS claims edit and rule validation solutions. For instance with our Tennessee state partner, we leverage EDIFECS to align claim payment with encounter requirements and intend to implement the same level of edits for Louisiana. Our placement of the EDIFECS application

will be at the front end of our claims processing to ensure edits occur prior to adjudication. In Tennessee, we have an **initial acceptance rate of more than 98 percent**. In accordance with the Systems Companion Guide, we will adhere to DHH's data elements and reporting requirements.

In accordance with Section 17.12, we understand that we will be responsible for payment of a LaHIPP participant's copayments and deductibles if the participant uses a provider that accepts the insurance as the primary payer and Medicaid as secondary payer. If the provider does not accept this payment arrangement, the participant will be responsible for the copayments and deductibles.

Our information systems are fully compliant with the requirements associated with HIPAA, P.L. 104-191, as amended or modified. We comply with HIPAA EDI requirements, including the HIPAA-compliant format version. Our systems are fully compliant with HIPAA privacy and transaction and code set standards. We use standard HIPAA 835, 837D, 837I, 837P, 270/271U, NCPDP, 275 claim attachments, 276/277 and 278 file formats for electronic transactions. We are in compliance with the ANSI X12N 837 provider-to-payer-to-payer COB transaction formats and 5010 EDI standards.

UnitedHealthcare uses CareOne, our care management platform, as our utilization management/prior authorization tool and system of record for all prior authorizations. All inpatient stay authorizations and outpatient service authorizations, for services that require authorization, are recorded there. As specified in 17.8.5, we will provide DHH with weekly encounter data on all prior authorization requests directly from our CareOne platform. The data will be reported electronically to DHH in a mutually agreeable format as specified in the Systems Companion Guide.

The information reported will include the following:

- Plan ID
- Authorization Type
- Provider NPI
- CPT/NDC/HICL/THERP CLASS
- CPT Modifiers 2
- CPT Modifiers 4
- Plan Authorization Status
- Authorization end date
- Authorization amount ($)
- Authorization notice date
- Plan Authorization Number
- Medicaid Recipient ID
- Provider Taxonomy
- CPT Modifiers 1
- CPT Modifiers 3
- Referring Provider NPI
- Authorization begin date
- Authorization Units
- Authorization received date
- Authorization Denied Reason

We have implemented custom systems, formalized processes and offer a designated team specializing in Medicaid encounter data integrity to make sure we provide the FI with complete and accurate encounter data for all levels of health care services provided through our contract. Our collection and submission process includes checkpoints that validate accurate processing and timely submission of encounter data files throughout the process.

Converting Paper Claims to Electronic Encounter Data (17.8.7)

The intake process for paper claims begins in our regional mail office where each incoming claim is opened, sorted, batched, date-stamped, imaged and assigned an internal control number for tracking.

Upon receipt, paper claims are converted to electronic data via iDRS, our combined document imaging, indexing and workflow management system, which captures images and integrates the claims into a workflow system used for processing. Paper documents and attachments are scanned using optical character recognition, which pre-populates claims electronically in CSP Facets. Data entry processors review the scanned images against the pre-populated fields and confirm the data elements were accurately transmitted into the correct claim fields. **We have strong balancing and controls to ensure completeness of capture from the mail room to the claim system.**

CSP Facets assigns unique document control numbers that permanently link images of the original paper claims to electronic version in CSP Facets. Electronic claims also receive a unique document control number upon loading into the system for tracking, logging and audit control purposes. All claims are stamped with their date of receipt to allow for real-time status tracking.

Once in CSP Facets the claim is processed in the same manner regardless of how it was submitted. Through our online provider portal, BayouCloud, providers can check the status of claims 24 hours a day, seven days a week, whether the claim was submitted electronically or via paper. In addition, our provider call center can assist providers who do not want to use BayouCloud to check claims status.

All claims processed through CSP Facets are automatically loaded into our NEMIS encounter system for validation and submission to DHH's FI in the appropriate HIPAA-compliant format.

Encounter Data from Subcontractors (17.8.8 and 17.8.9)

UnitedHealthcare has several mechanisms in place to validate the submission of accurate and complete provider and subcontractor encounter data, including operating agreements, operations meetings, joint operating committees, dedicated encounters staff, statistics and reports, governance calls and audits. We have excellent and long-standing working relationships with subcontractors such as OptumRx and March Vision and they consistently meet our defined expectations. Our contracts require vendors to process encounters timely and accurately. Our provider and subcontractor agreements obligate providers to submit timely and accurate claims.

Payments are contingent on the provider or subcontractor meeting all contractual obligations, including the claims and encounter submission guidelines in applicable provider manuals and companion guides. Claims from our subcontracted providers are imported into NEMIS for submission to DHH's FI. Subcontractors do not submit encounters directly to DHH's FI.

We monitor rejection and denial volumes to identify all types of providers (including sub-capitated, atypical and non-participating) in need of additional education. Provider outreach is led by our provider claims educator Deborah Tillman, using our provider relations advocate team or claims coding staff. We will not submit separate encounter files from our subcontractors. All claims and encounter education team members are located in Louisiana.

As part of our compliance program, we have a Delegation Vendor Oversight Committee (DVOC) that reviews the activities performed by delegated subcontractors on quarterly basis.

Our DVOC is led by program integrity officer Larry Smith and comprises UnitedHealthcare team members with expertise from a legal and compliance perspective as well as provider and vendor contracting. An annual in-service is offered to all of our top tier subcapitated providers, subcontractors and atypical providers where we reinforce the necessity of accurate and timely submission and resubmission of encounter data.

If the committee identifies deficiencies, we implement corrective action plans and conduct more frequent audits. We use three strategies to manage our subcontractors' non-compliant encounter data, including:

- Implement corrective action plans
- Re-contract to a fee-for-service (FFS) methodology
- Terminate contract

Providers contracted on a capitated basis are required to submit zero-pay claims, which process through our claim system and are subject to the same edits and validations as FFS claims.

Billing Requirements (17.8.10)

We have used DHH provider billing manuals and Companion Guides to become familiar with the claims data elements that must be included in encounters. Our claims data is housed in our CSP Facets transaction processing system, which serves as the main data source for encounter data extracts. CSP Facets uniquely identifies claims submitted by service provider based upon the submitted NPI and edits claims to ensure all required data is present to identify the "pay to" provider and process the claim.

Our platforms actively store a minimum of six years of historical information including membership eligibility, provider and claims data for audit and reporting purposes. Ten years of claims history is available in our archival systems. Our systems configuration supports retaining all required data elements in claims history for the purpose of creating encounters that are compatible with DHH and its FI's billing requirements.

Standard Payment Rules (17.8.11 thru 17.8.16)

We adhere to federal and state payment rules in the definition and treatment of claim data elements that are standard fields in claim and encounter submissions, including units of service. To verify adherence to claims processing standards, we use multiple quality audits and programs to monitor claims accuracy. Our approach to claims monitoring and quality includes pre-disbursement and post-disbursement review and prevention, including root cause analysis and resolution.

These reviews are performed by our national business process quality management (BPQM) team, which is separate and independent from claims operations, providing integrity in the audit oversight process. We include all medical claims in our reports and audit processes. BPQM audit personnel have broad experience in claims processing, possess strong analytical skills and work closely with our local claims department to address issues identified from the audits. This collaboration supports performance improvement by enabling us to make corrections to the system and to provide feedback and mentoring for processors.

We will submit paid, denied, adjusted, zero dollar and voided claims as encounters to the FI. We understand DHH will establish the appropriate identifiers to indicate these claims as encounters and information is provided in the Systems Companion Guide.

Our encounter team verifies that encounter files contain settled claims, adjustments, denials or void, including but not limited to, adjustments necessitated by payment errors, processed during that payment cycle as well as encounters processed during that payment cycle from providers with whom we have a capitated arrangement.

NEMIS processes encounters across the breadth of UnitedHealth Group's Medicaid businesses and initiates submission, tracks responses, and provides error correction and resubmission of Medicaid encounters. We understand that any submission which contains fatal errors that prevent processing, or that do not satisfy defined threshold error rates, will be rejected and returned to us for correction and resubmission to the FI in the next payment cycle.

Ms. Warren and our national encounter business team have thoroughly reviewed the list of encounter edit codes in the Systems Companion Guide. To maintain integrity of processing, we will address any issues that prevent processing of an encounter based upon the following standards:

	Acceptable Standard
Reported Repairable Errors	90 percent addressed within 30 calendar days
	99 percent addressed within 60 calendar days or within a negotiated timeframe approved by DHH

We understand failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan may result in monetary penalties.

Truthfulness, Accuracy and Completeness of Encounter Data (17.8.17 and 17.8.18)

The multiple checkpoints and validations that take place in our end-to-end encounter submission process are also used to aid in upstream process and system issue identification. For example, our encounters upstream remediation team performs quarterly scheduled reviews of claims for accuracy of transaction processing. These audits, in coordination with the CSP Facets system edits, confirm the validity of our claims data to verify accurate encounter reporting. Root cause analysis is completed and upstream system or process remediation is deployed to further improve the overall encounter program completeness and accuracy.

Through NEMIS, we follow a systematic process to meet the requirements for encounter data submission:

- ***Encounter Data Submission:*** We consistently apply policies and procedures that leave no room for variations in interpretation. This increases the accuracy of the data submitted.
- ***Coding Errors on Submitted Claims:*** We work with our provider community to confirm they are familiar with clean claim submissions guidelines to verify data are translated into accurate encounters. Incorrect selection or sequencing of the primary diagnosis code, omissions of required claim data or receipt of vendor encounter data in an incorrect format may all lead to encounter rejection.
- ***Encounter Correction and Monitoring:*** We review all response files after each submission. If the encounters are rejected due to programming error, we correct the error and resubmit the encounter transactions to DHH. In addition, on a monthly basis, our encounter team produces a series of encounter data management reports to review

encounter submission trends and completeness. Trend analysis reports contain tracking of the top issues experienced with the prior month's encounter submission. A mitigation plan is developed to correct identified issues before the next submission.

As required, an attestation to the truthfulness, accuracy and completeness of all encounter data submitted will be included. We will configure our submission to meet the 100,000 encounter claim limitation. If we must exceed the limit, we will seek prior approval.

We will make an adjustment to encounter claims when we discover the data are incorrect, no longer valid or some element of the claim not identified as part of the original claim needs to be changed except as noted otherwise. We understand that if DHH or its subcontractors discover errors or a conflict with a previously adjudicated encounter claim, we are required to adjust or void the encounter claim within 14 calendar days of notification by DHH or a specified date approved by DHH. Additionally, we acknowledge we must obtain prior approval from DHH for any submission to DHH's FI that numbers greater than 100,000 encounter claims.

Necessary Changes Based Upon Systems Companion Guide

We did not identify any areas where changes will be necessary based on requirements stated in the Systems Companion Guide.

Limitations or Disparities to Requirements in Sections 17.2, 17.8 and 17.10

Section 17.2 – Claims Processing

UnitedHealthcare will comply with the requirements specified in Section 17.2 and we did not identify any limitations or disparities to report. Key metrics/deliverables identified:

- Accept or reject claim within five business days of receipt
- Process 90 percent of all clean claims within 15 business days of receipt
- Process 99 percent of all clean claims within 30 calendar days of receipt
- Pay or deny all pended claims within 60 calendar days of receipt

Section 17.8 – Encounter Data

We have thoroughly reviewed the requirements of Section 17.8 and did not identify any limitations or disparities to report. Key metrics/deliverables identified:

- Transmit encounter data within 60 days after contract start date
- Submit complete encounter data (paid or denied) monthly by the 25th calendar day of the following month
- Submit medical encounters at the document level and pharmacy at-line level
- Do not exceed the 5 percent error rate threshold on acceptance rates to the FI
- Ensure that medical record reviews have limited discrepancy with encounter submissions
- Submit prior authorization encounter data weekly

Section 17.10 – Pharmacy Claims Processing

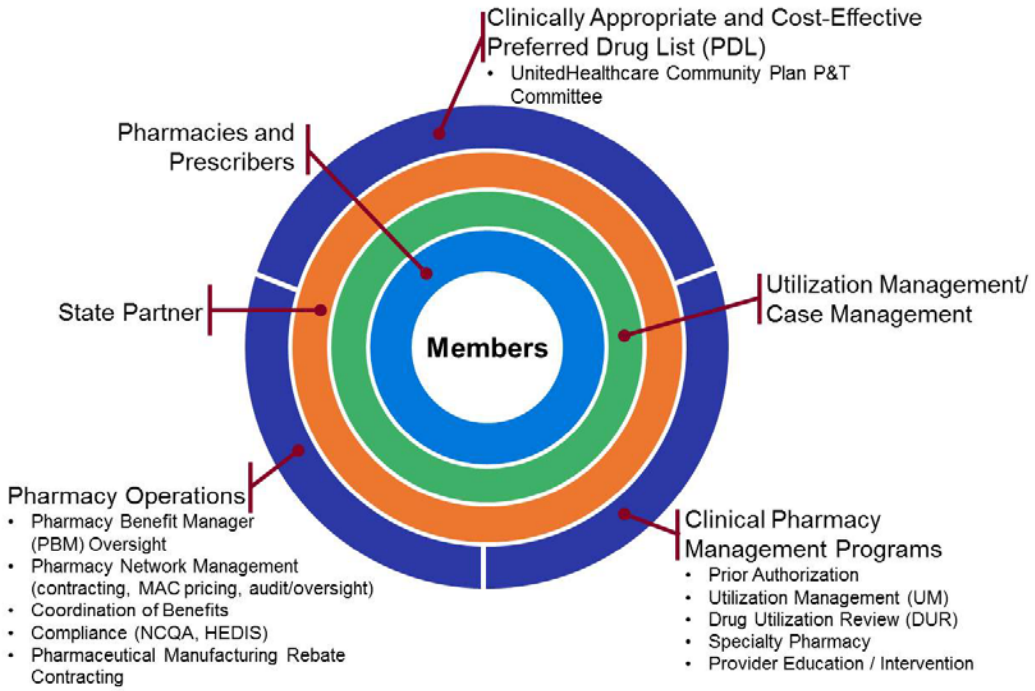
We have thoroughly reviewed the requirements of Section 17.10 and did not identify any limitations or disparities to report. Key metrics/deliverables identified:

- Transmit pharmacy encounter data with claim edits that include eligibility, drug coverage, benefit limitations, prescriber and prospective/concurrent drug utilization review edits
- Update national drug code pricing information at least every seven calendar days
- Maintain permanent history of "once-in-a-lifetime" services
- Ensure timeliness of pharmacy claims information for the drug rebate program such that the claims information is sent before the end of the month that follows the end of the quarter (following a quarterly process)

Systems Capabilities for Section 17.10 Pharmacy Claims Processing

Under the oversight of our chief medical officer Dr. Ann Kay Logarbo, our pharmacy team will provide pharmacy services to members enrolled in the Bayou Health program. UnitedHealthcare offers a comprehensive suite of pharmacy benefit management services to more than 27 million people, delivering drug benefits through more than 66,000 retail pharmacies nationwide. The experience of supporting Medicaid pharmacy benefits management nationally since 2001 has provided us with an understanding of the unique requirements of the Medicaid managed care business.

As illustrated in the following graphic, UnitedHealthcare collaborates with prescribers, pharmacies and our pharmacy benefits manager (PBM) to provide member-centric pharmacy operational and clinical services.



Pharmacy System Requirements (17.10.1)

We have an automated claim and encounter processing system for pharmacy claims that will support the requirements of this contract and provide accurate and timely processing of claims and encounters. We use claims administration software purchased from an external vendor and modified internally with custom features. We have used our current system, the RxClaim online

transaction processing system, to process all claims since 1992. RxCLAIM includes all claim plans and benefit structures. We have modified this standard RxCLAIM program with a variety of custom features that have been developed and are used exclusively by us. These custom features, and the ongoing development of and familiarity with these custom features, provide capabilities that are not offered by other RxCLAIM users. We license RxCLAIM to assist with the claims processing function and we purchase regular upgrades from Catamaran to ensure the most current functionalities. We provide our own support for the custom applications.

Pharmacy claims adjudication performed within RxCLAIM always contains the latest adjudication status. The provider phone representatives have direct access to RxCLAIM and the claims adjudication data.

We continually monitor federal regulations to maintain compliance with regulatory mandates related to standards. Our pharmacy claims processing operates under National Council for Prescription Drug Programs (NCPDP) version 5.1, in compliance with current HIPAA billing standards, and accepts billing under NCPDP version D.0. We expect our system to be fully capable to accept NCPDP version D.0 format as required and without additional charge.

RxCLAIM functionality includes drug coverage, benefit limitations, prescriber and prospective/concurrent drug utilization review edits. RxCLAIM provides for automated updates to the National Drug Code (NDC) file including all product, packaging, prescription and pricing information. Our drug files updates for both retail and specialty drugs are sent twice weekly and include pricing.

We will comply with the claims history requirements in Section 16.13. Our platforms actively store a minimum of six years of historical information including membership, eligibility and claims data for audit and reporting purposes and 10 years in archival systems. We will provide 48-hour turnaround or better on request for access to information in machine readable form that is between 6 to 10 years old.

On all claims, we will provide the manufacturer number, product number and package number for the drug dispensed, in accordance with NCPDP protocol. This information comes from the actual package from which the drug is usually purchased by a provider, from a supplier whose products are generally available to all pharmacies and reported in one or more national compendia.

We will work with DHH to identify any medications that it considers to be a “once in a lifetime” benefit and maintain a permanent history based upon the service date.

Pharmacy Rebates (17.10.2)

We will submit all drug encounters, with the exception of inpatient hospital drug encounters to DHH pursuant to the requirements of Section 17.10.2. We understand DHH or its vendor will submit these encounters for federal supplemental pharmacy rebates from manufacturers under the authority of the DHH Secretary pursuant to Section 2501 of the Patient Protection and Affordable Care Act (PPACA).

At the request of DHH or its FI, we will submit pharmacy claims information in an electronic format that is suited to allow for integration with the State's pharmacy rebate program. We further understand that DHH will establish the frequency of these information requests, and we

will comply. We understand that the pharmacy rebate process is a quarterly process and claims information is usually required before the end of the month that follows the end of the quarter.

Pharmacy Encounters Claims Submission (17.10.3)

We will submit a weekly claim-level detail file of pharmacy encounters to DHH which includes individual claim detail information on each pharmacy claim dispensed to a Medicaid patient, including but not limited to the total number of metric units, dosage form, strength and package size, and NDC of each covered outpatient drug dispensed to Medicaid members. The weekly submission will comply with Section 17.5.6 requirements and the MCO Systems Companion Guide.

In accordance with NCPDP protocol, our system is able to identify pharmacy claims filled by 340B enrolled providers for members to ensure the State correctly excludes 340B utilization from CMS rebate invoices to manufacturers.

Disputed Pharmacy Encounter Submissions (17.10.4)

We understand and acknowledge that on a weekly basis, DHH will review our pharmacy encounter claims and send a file back to us of disputed encounters that were identified through the drug rebate invoicing process.

Within 60 calendar days of receipt of the disputed encounter file from DHH, we will, if needed, correct and resubmit any disputed encounters and send a response file that includes:

- Corrected and resubmitted encounters as described in the Rebate Section of the MCO Systems Companion Guide, or
- A detailed explanation of why the disputed encounters could not be corrected including documentation of all attempts to correct the disputed encounters at an encounter claim level detail, as described in the Rebate Section of the MCO Systems Companion Guide.

We understand that in addition to the administrative sanctions in Section 20, failure to submit weekly pharmacy encounter claims files or a response file to the disputed encounters file within 60 calendar days as detailed above for each disputed encounter will result in a quarterly offset to the capitation payment equal to the value of the rebate assessed on the disputed encounters being deducted from our capitation payment.

Use of a Pharmacy Benefits Manager (17.10.5)

We will assume responsibility for all prescription drug services as found in Section 17.10.5, Use of Pharmacy Benefits Manager (PBM). Our pharmacy management team will manage the pharmacy benefit for Bayou Health members. Our affiliate, OptumRx will serve as our PBM. OptumRx is a leading innovative and collaborative PBM with vast experience providing pharmacy benefit services to both commercial and public-sector health plans. Particularly relevant is OptumRx's experience providing Medicaid PBM services for UnitedHealthcare in numerous states since 2001. This provides OptumRx with an understanding of the unique requirements of the Medicaid managed care business and has proven to be an effective partnership.

In the majority of states that UnitedHealthcare serves, we use a preferred drug list (PDL) developed in conjunction with the representative Pharmacy & Therapeutics (P&T) Committee. The PDL is developed to assure the latest in clinically appropriate, evidence-based therapies are made available to our members. The states leverage our capabilities related to medical and

clinical expertise, assessment of most current clinical practices and deployment of evidence-based protocols.

We have also worked with several states to successfully implement a common Medicaid PDL. The approaches varied so that our experience is extensive in this aspect of PDL management. In one market, we worked collaboratively with six other MCOs to establish a core of common medications. This provided the MCOs with the ability to independently review new drugs and formulations as well as conduct on going reviews of the PDL to identify clinically appropriate cost savings initiatives through their own P&T committees with final recommendations being presented to the State.

We are confident in our ability to develop a common PDL in collaboration with other MCOs in Louisiana with facilitation and approval by DHH.

OptumRx will process and pay claims in accordance with Section 17. We will submit a plan for oversight of the PBM's performance to DHH for approval prior to implementation. Our plan will comply with contract and DHH requirements.

Limitations for Section 17.10 Pharmacy Claims

We did not identify any areas where changes will be necessary based on requirements stated in the NCPDP located in the Systems Companion Guide.

Meeting the Requirements in Section 17

Nationally, we have been processing Medicaid claims for 32 years in 23 states, serving more than 4.8 million members. We have thoroughly reviewed the requirements of Section 17 and will meet all the requirements.

Demonstrated Local Experience

Our enterprise resolution team is a cross functional break/fix team established to evaluate and remediate both short- and long-term production defects. This team has substantially improved our operations accuracy and effectiveness by initiating root cause remediation projects that span across the entire enterprise including operations, network, clinical, claims payment and collection, and encounters. All required metrics have been maintained while others continue to improve. This team was organized in Q3 2012.

- Through the efforts of our enterprise resolution team we enhanced our claims data submission to fully comply with DHH's FI required data fields. This ensures we are aligned with future requirements associated with claims payment and encounter data submission accuracy.
- We implemented our fully functioning Provider Service Model including provider call center, provider claims resolution specialists, claims project management and claims rework team, local provider advocates and the market service agent team.
- An internal team was established, including two Louisiana-based claims/information technology (IT) specialists to resolve and manage claims issue resolution and ongoing claims management responsibilities.
- Daily claims calls are held with multifunctional teams involved to efficiently address any claims issues in a timely manner.

As part of our commitment to bring resources to Louisiana, we will move our claims and provider service operations to the State.

Experience

Working as a full-risk plan is a core competency of UnitedHealthcare. We have built an advanced infrastructure for processing and paying claims submitted by providers of health care services to our members in 23 states. Nationally, we have the operational experience, demonstrated success, and ability to adjust to the changing health care market and the needs of our state customers. **The American Medical Association's 2013 National Insurer Report Card rated UnitedHealthcare No. 1** in claims processing accuracy among seven leading health insurers. This operational experience provides the foundation for successful claims management and administration for all of our Medicaid customers, including Tennessee, Ohio and Maryland.

Tennessee: Our experience includes several implementations and expansions over the last several years. These include: Middle and West Tennessee service area expansions, behavioral health and long-term services and supports (LTSS) integration and Medicare Dual Special Needs Plan (D-SNP) coordination. Our enhanced Facets claims platform, CSP Facets, goes live January 2015.

Ohio: Our affiliated statewide Medicaid plan in Ohio upgraded to our enhanced CSP Facets claims platform May 1, 2013. Simultaneously, we expanded by 60,000 members July 1, 2013. We not only maintained high performance levels, but improved in several key claims metrics, including the auto-adjudication rates from 79.5 percent to 82.5 percent.

Maryland: Our Medicaid plan in Maryland was the first plan to transition to CSP Facets platform in August 2011 and also has experienced consistent and accurate claims performance since implementation.

Claims Performance	Tennessee		Ohio		Maryland	
	2013	2014	2013	2014	2013	2014
Processed within 30 days	98.6%	98.5%	99.5%	99.8%	99.2%	99.9%
Claims Payment Accuracy	99.3%	99.1%	99.9%	100%	100%	100%

X.2 Explain in detail your process for ensuring that all claims (paid, denied, adjustments and voids) are submitted to the Fiscal Intermediary timely and accurately. (10 points)

As a current contractor for Bayou Health in Louisiana we have gained proficient experience in transmitting 837 claim files to the FI timely and accurately on a daily basis. We understand going forward this same attention to detail will be required as we submit the 837 encounter files to the FI.

Locally, oversight to the claims processing and information systems area is provided by Mr. Lirette. This diagram depicts the claims process flow:

[redacted]

CSP Facets is a state-of-the-art platform with advanced functionality that enables us to achieve efficiency and accuracy in our claim processing operations. It is the next generation of the TriZetto Facets claims platform and is the heart of our architecture. CSP Facets supports a full continuum of claims processing steps and functionality for the Bayou Health program including:

- Maintenance of covered benefits for all eligibility groups
- Maintenance of reference files including CPT, HCPCS, ICD-10
- Utilization management, including prior authorizations and referrals
- Claims logging and tracking
- Claims aging
- Claims edits and denial codes
- Claims pricing and adjudication
- Check writing and electronic funds transfer (EFT)
- Production of paper and electronic remittance advices
- Claim adjustments and voids
- Production of claims management reports

Monitoring Process for Accurate and Timely Claim Adjudication

As evidenced by our experience of processing and paying claims in 23 states, we consistently meet or exceed federal and state prompt payment requirements. Nationwide in 2013, we processed nearly 15 million claims using our CSP Facets claims processing system.

We have built an advanced infrastructure for processing and paying claims that are submitted by providers of health care services to our members throughout the nation. Our leading-edge

technical systems and highly trained, Louisiana-based claims processing staff are critical to our ability to meet or exceed increasingly stringent standards for payment promptness and accuracy. These systems and staff are also a reflection of the expertise we have gained from 32 years of processing claims and payments and serving nearly 5 million Medicaid members.

We will comply with the following requirements:

- Accept or reject claim within five business days of receipt
- Process 90 percent of all clean claims within 15 business days of receipt
- Process 99 percent of all clean claims within 30 calendar days of receipt
- Pay or deny all pended claims within 60 calendar days of receipt

Our claims team continuously monitors the claims adjudication and payment process to promote accurate processing and minimize the likelihood of adjusting already-paid claims. As part of our effort to self-monitor, self-report and continuously improve our operations, we established a Claims Quality Assurance program based upon a set of quantifiable measures and multiple initiatives to monitor our claims processing operation and resolve deficiencies. We monitor measures through a combination of automated system checks and manual assessments which drive quality improvement activities that include cross-functional efforts.

During program pre-implementation for new contracts and in support of ongoing maintenance of our existing operations, we validate our claims systems and processes to confirm accurate claims payment by performing the following activities:

- Facility and ancillary contract testing verifies the contract configuration based upon contract intent review. Testing includes data integrity report analysis, execution of contract scenario tests with full integration of benefit packages, special processing instructions and production load accuracy verification.
- Fee schedule load is a program that validates data load against source files and produces error reports for review and approval by our manager of claims operations.
- Professional contracts set up provider type templates for comparison against new provider loads to the system and compares reports to verify the new contract fits our templates. The configuration templates reduce the number of potential errors through standardization.
- Claim edits and reimbursement policies test our system configuration against the state of Louisiana’s and UnitedHealthcare’s reimbursement policies to validate accurate claims adjudication.
- Benefits and authorization updates test our benefit and authorization system configuration against the State’s and UnitedHealthcare’s guidelines. Testing artifacts are produced.
- Metrics and controls report installation accuracy trends are used for continuous quality improvement.
- Once our claims systems and processes have been validated, our claims team, regardless of the method of claims submission, uses CSP Facets to track and process all claims according to type and in date order. To validate accurate and timely claim adjudication, the claims team:

- Conducts check runs at least two times a week to issue payments and generate remittance advices indicating paid and denied claims.
- Generates various reports to monitor timeliness standards and trigger research of aging claims.
- Conducts operational meetings to determine cause and subsequent remediation of any missed or nearly missed metrics.
- Engages the Claims Quality Assurance program based upon a set of quantifiable measures and multiple initiatives to monitor our claims processing operation and resolve deficiencies both proactively and reactively.
- Conducts audit reviews to examine transactions for specific problems and identify error sources.
- Conducts post-training certification reviews to check the financial and procedural accuracy of claims processors.

In addition to CSP Facets key components of our claims management solution include:

[redacted]	[redacted]
[redacted]	
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[redacted]	[redacted]
[redacted]	[redacted]

Key features of our system functionality include:

- Performing automated edits and validations, using NEMIS, to confirm the accuracy and completeness of encounter data using processed claims data from CSP Facets or data from our capitated providers. NEMIS applies general data validations (e.g., presence of provider IDs, NPI, taxonomy and member Medicaid IDs) to confirm all HIPAA 837 required fields are present and in the correct format (e.g., field length, character or numeric) and meet DHH's encounter submission requirements. We submit all claims that pass these validations. Claims that do not pass these validations receive an error-submitted flag on the finalized claim tables, and the error reason is written to an error table for research and inclusion in future submissions.
- Extracting adjudicated claims data from CSP Facets using the CSP Facets claims extract program, which sweeps the claims database and picks up all adjudicated claims (status equals paid, denied and reversed) date stamped since the last monthly encounter extraction.
- Identifying real-time accurate history with dates of adjudication results of each claim such as paid, denied, pended, adjusted, voided, appealed, etc., and follow-up information on disputed claims.
- Identifying the date of payment (e.g., the date of the check) and the number of the check or EFT.
- Identifying all data elements as required by DHH for encounter data submission as stipulated in Section 17.8 and the Systems Companion Guide.
- Accepting submission of paper-based claims and electronic claims by contracted providers and non-participating providers according to UnitedHealthcare policies, as approved by DHH.
- Accepting submission of electronic adjustment and voided transactions.
- Accepting submission of paper adjustment and voided transactions.
- Paying and submitting claims at $0.00.
- Reconciling cash disbursements to submitted encounters to validate completeness.

UnitedHealthcare will not derive financial gain from a provider's use of our electronic claims filing functionality or services offered by us or a third party. We understand this should not be construed to imply that providers are not responsible for payment of applicable transaction fees or charges.

We assume all costs associated with claims processing, including costs for reprocessing encounters due to errors caused by something we did or due to a system within our span of control.

We will not employ off-system or gross adjustments when processing corrections for payment errors, unless we request and receive prior written approval from DHH. Any such adjustments or corrections will be included in our encounter data submissions.

For purposes of network management, we will notify all contracted providers (including capitated providers) to file claims associated with covered services directly to us or our subcontractors, on behalf of Bayou Health Medicaid members.

We agree that at such time that DHH presents recommendations concerning claims billing and processing that are consistent with industry norms, we will comply with those recommendations within 90 calendar days from notice by DHH.

Providers can obtain claim processing status information via our provider portal or phone as explained below.

No Wrong Door Approach

We process provider payments for both paper and electronic claims using the same procedures and along the same timeline. In fact, we offer a "no wrong door" approach to claim intake, making it easy for providers to transact with our organization. Our United Front End process delivers claims to the appropriate processing platform based upon each member's demographic data and corresponding eligibility information. In other words, regardless of the line of business (e.g., Medicaid, Medicare or commercial), claims will be routed to the appropriate platform for processing. Claims data for various programs flow through the same channel, verifying appropriate routing for all provider-submitted claims including, paper, electronic and online submissions.

Our claims processing system assigns a unique identification number to all claims for tracking, logging, audit control and reporting accurate performance measures. All paper claims are stamped and tracked with their date of receipt to allow for real-time status tracking. Our online claims reporting system automatically updates as claims are received in CSP Facets, tracking each claim by type (professional or institutional) and reports each claim transaction by date, line detail level and type to include interest payments.

We begin the claims adjudication process by subjecting all claims entering our system to initial validation edits before they are transferred into CSP Facets for processing, including:

- Pre-edit claims to verify the member and the provider IDs and validate all necessary data elements are present to allow claim processing and submission to DHH's FI
- Research questionable member IDs and sending a rejection notice to the provider when a valid member ID cannot be found in CSP Facets

- Research invalid provider IDs and, if they cannot be corrected, adding a new provider record to our National Provider Database (NDB)

Upon completion of these initial validation edits, our claims team subjects claims to further validation and edits for member eligibility, provider contracting and prior authorization. CSP Facets determines if the claim can be auto-adjudicated and, if the claim criteria indicate auto-adjudication, uses built-in logic to automatically process and price the claim according to claim type.

Claims that cannot be auto-adjudicated and require special intervention outside the normal claims processing cycle (e.g., procedures that require medical record review or prior authorization) are diverted for manual adjudication by our Louisiana-based skilled claims processors.

Claims Processing and Payment Processes

Our claims process, as described below, verifies the following:

- Accurate receipt of paper and electronically submitted claims and submission into CSP Facets for processing.
- Claims are processed and paid using the same tools and process regardless of the way they were submitted to us (paper or electronic).
- Using CSP Facets we perform initial claim validation edits and additional claim edits for member eligibility, provider contracting and prior authorization.
- Claims are automatically adjudicated if CSP Facets determines the claim meets the criteria for auto adjudication.
- Claims that cannot be automatically adjudicated by CSP Facets are reviewed and manually adjudicated by our skilled claims processors.
- CSP Facets/Medicaid is the payer of last resort by identifying potentially liable third parties (e.g., Medicare).
- Adjudicated claims are paid accurately and in a timely manner.
- We monitor the claims process to verify accurate and timely claim adjudication and payment.

We process provider payments for both paper and electronic claims using the same procedures and along the same timeline. As presented in the flowchart below, Claim Review Process, we begin the claims adjudication process by subjecting all claims entering our system to initial validation edits before they are transferred into CSP Facets for processing, including:

- Pre-edit claims to verify the member and the provider ID and validate all necessary data elements are present to allow claim processing
- Research questionable member IDs and sending a rejection notice to the provider when a valid member ID cannot be found in CSP Facets
- Research invalid provider IDs and, if they cannot be corrected, adding a new provider record to NDB

Claim Review Process

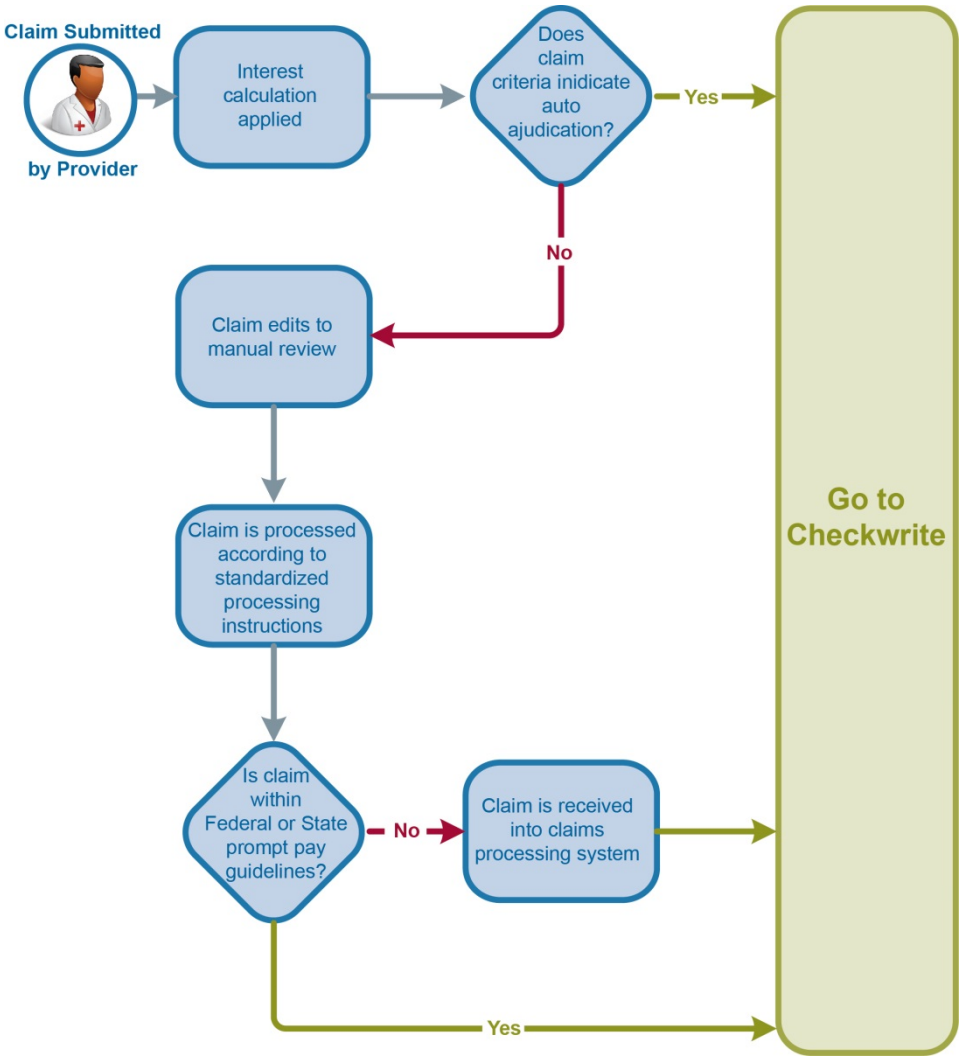

Figure 69. Claim Review Process. High-level flow illustrating the point in which interest calculation occurs.

Upon completion of these initial validation edits, our claims team subjects claims to further validation and edits for member eligibility, provider contracting and prior authorization. CSP Facets determines if the claim can be auto adjudicated and, if the claim criteria indicate auto-adjudication, uses built-in logic to automatically process and price the claim according to claim type.

Claims that cannot be auto adjudicated and require special intervention outside the normal claims processing cycle (e.g., procedures that require medical record review or procedures that require prior authorization) are diverted for manual adjudication by our Louisiana-based claims processors.

Provider Training

Accurate claims processing begins with the quality of claims submitted by providers. Ongoing training to providers and key staff is essential as we transform the delivery system. Under the direction and oversight of Ms. Tillman we conduct provider education and trainings through

face-to-face meetings, group sessions, town halls, mailings and fax. We have been proactive and industry leading in developing specific ICD-10 training. Finally, we provide a dedicated EDI hotline as a convenient method for providers to receive electronic claims support through our EDI support team.

To ensure providers get the training and assistance they need, our provider advocates work throughout the State to educate, train and provide ongoing support with claim/billing requirements and issues. We administer training to newly contracted providers and recognize they may lack experience when working with managed care.

In continuously looking for opportunities to improve our claims submission processes, we leverage a variety of methodologies that also help our providers be more efficient and accurate in their claims submissions, including:

- ***Claims Lab Training:*** We conduct claims lab training sessions for providers, many of whom are unfamiliar with electronic claims submission processes. This hands-on training promotes accurate claims submission, thereby improving claims payment turnaround times and better tracking of the claim submission process.
- ***Online/Phone Claims Status:*** Providers can access the status of their claims via telephone or on our provider portal, BayouCloud, 24 hours a day, seven days a week.
- ***Provider Education:*** We provide ongoing education on the benefits of electronic claims submission through in-person contact, training materials and provider newsletters.
- ***Claims Deep Dive Initiative:*** We conduct an annual audit of all standard operational procedures relating to claims processing.
- ***Provider Account Management Program:*** We meet with key providers to assess their accounts receivable days against our payment timeliness and accuracy, and identify issues around gaps or discrepancies in processing and payment.

BayouCloud

We continue to pursue innovative solutions to streamline and simplify our provider administrative experience. Our BayouCloud technology is the next evolution of our online provider tools. BayouCloud is the foundation of our goal to provide a single provider platform, bringing together multiple websites and incorporating new applications to improve efficiencies for our providers. With 24 hours a day, seven days a week accessibility, providers can use BayouCloud technology to conduct business with UnitedHealthcare any time it is convenient for them. By logging in once to a single and secure portal, providers can access all current online resources, plus new solutions aimed at streamlining and simplifying interactions, such as:

- ***Claims Management:*** Providers will be able to manage their accounts receivable with greater ease due to more detailed information being provided and increased granularity, and easy access to information will decrease claim inquiries and resubmissions. Features include claims search detail (payment/check info, edits, codes, line level payment); clear claim status remark codes; and additional reporting features to assist in account reconciliation.
- ***Claims Reconsiderations:*** Registered users of BayouCloud are able to submit claim reconsiderations with attachments, which saves time and money and provides seamless

visibility to each reconsideration submission by providing confirmation of receipt and real-time tracking capabilities.

The following screenshot illustrates what a provider may see after logging into the secure cloud portal.

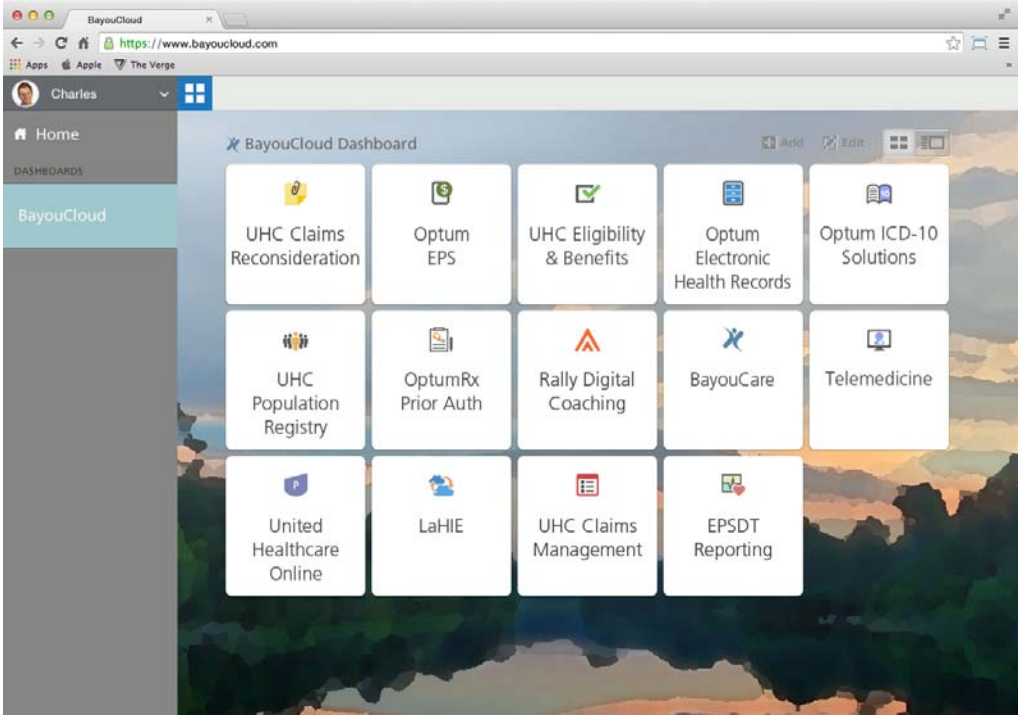

Figure 70. BayouCloud Dashboard. Preview of the BayouCloud portal with a sampling of some of the applications that will be available.

UnitedHealthcare is transitioning from our traditional web portals to applications hosted within our cloud portal. We are starting with the administrative functions that providers commonly need. The cloud provides a central access point for the suite of UnitedHealthcare websites and applications, many with the simplicity of single sign-on security.

As we deploy our advanced technology solutions, we are ready and willing to offer infrastructure and expertise for any or all of our data solution components to the State and to other MCOs to enable and facilitate data sharing.

The portal is integrated with our CSP Facets platform and gives providers access to a variety of comprehensive plan and member-specific information including the ability to:

- View member eligibility
- View a display of recovery projects
- View claim adjustment requests
- View payment remittance
- View provider profile, EPSDT, PCP Panel reports
- View claim trends
- View claim status inquiry
- Submit claims
- Request demographic changes
- Request electronic payments
- Access links to industry news and information

In addition, to being able to access claims information 24 hours a day, seven days a week through our provider portal, providers can also access the status of their claims via telephone by calling our Louisiana-based provider services call center.

Our CSP Facets system supports a Council for Affordable Quality HealthCare (CAQH)/CORE compliant interface to the automated clearinghouse (ACH) that allows providers to request and receive EFT of claims payments.

UnitedHealthcare has written procedures available to providers in both in hardcopy and on our provider Web portal explaining our claims submission process which includes:

- The process for documenting the date of actual receipt of non-electronic claims and date and time of electronic claims
- The process for reviewing claims for accuracy and acceptability
- The process for prevention of loss of such claims
- The process for reviewing claims for determination as to whether claims are accepted as clean claims

These procedures will be approved by DHH prior to being available to providers.

Prompt Payment

Our local claims operations management team, led by Mr. Lirette, applies multiple strategies, innovations, and controls that enable timely claim processing, daily reporting on inventory, receipts and output and workforce management augment strategies to increase auto-adjudication rates, fully compliant with each specification and requirement outlined in the Section 17.2 Claims Processing. CSP Facets is configured with the Bayou Health program's business rules and criteria to enable auto-adjudication and identify claims requiring processing exceptions (e.g., requiring documentation for medical necessity).

X.3 Describe your ability to provide and store encounter data in accordance with the requirements of the RFP and the Louisiana Medicaid specific requirements described in the Systems Companion Guide. (5 points)

Our ability to Provide and Store Encounter Data

Our claims data are housed in CSP Facets, which serves as the main data source for encounter data extracts. Based upon adjudicated claims data from CSP Facets, we collect encounter data in HIPAA transaction formats and code sets through our encounter data submission and reporting system, NEMIS. This system processes encounters across the breadth of UnitedHealth Group's Medicaid businesses and initiates submission, tracks responses, and provides error correction and resubmission of Medicaid encounters.

While we are very familiar with HIPAA transaction and code set regulations, we acknowledge the importance of using the System Companion Guide and Implementation Guide to achieve a successful encounter program. We plan to conduct comprehensive end-to-end testing prior to the operational start date. Successful end-to-end testing with the FI will be dependent upon understanding and deploying the specific requirements noted within both documents.

Commitment from Our Local Leadership Team

Our local executive team is dedicated to accurate and timely encounter submissions. Under the leadership of Mr. Lirette, the locally based encounter data quality coordinator and claims

administrator Angela Warren will meet biweekly to review reports on encounter submission trends and completeness as well as discuss corrective actions throughout the payment and encounter submission process. We attend and host a weekly meeting with DHH and DHH's FI, Molina, to discuss prevention of errors and correct any identified issues. Going forward as we transition to full claims adjudication and encounter data management and submission, we propose maintaining the same type meetings and schedule with DHH.

Encounter Submission Process

Our encounter data collection and submission process confirms all data provided to the State has first been tested for accuracy, completeness, logic and consistency. We submit encounter data in the HIPAA-standard approved by DHH, using files generated in NEMIS. We comply with CMS and HIPAA standards for electronic submission, security and privacy, and we verify our subcontractors adhere to these standards as well.

The collection and submission process presented below validates accurate processing and timely submission of encounter data files due to checkpoints included in the process.

[redacted]

Claim Data Acquisition

All required data elements are retained in claims history for use in creating the encounter submissions. Our claim extract program picks up all paid, denied and adjusted claims from the claims system to be included in our NEMIS repository. Claims from our subcontracted or capitated providers are pulled into NEMIS through our Vendor Database. Providers contracted on a capitated basis are required to submit zero pay claims, which process through our claim system and are subject to the same edits and validations as FFS claims. All paper claims are

converted to electronic data which is populated in the claims system. The claims system assigns unique document control numbers to link the claim to the original image. Once in the claim system, it is processed in the same manner regardless of how it was submitted to us. We schedule data extracts and loads to meet State-specific timeliness requirements.

Data Validation

NEMIS performs automated edits and HIPAA validations to confirm the accuracy and completeness of encounter data using processed claims. We submit all claims that pass these validations, and will certify HIPAA transaction readiness through EDIFECS. Claims that do not pass these validations receive an error and are pended for research by the encounters management team. The team partners with functional operating teams, including subcontracted vendors, to resolve and submit the pended encounters. Nonetheless, we will ensure we meet the timeliness requirements for encounters.

Encounter File Submission

We have three years of experience submitting HIPAA compliant 837 files to DHH daily. We will use NEMIS to submit encounters under this new contract. All claims, including paper claims and zero-pay claims for capitated providers, are included in our encounter file submissions.

Within 60 days after the contract start date, compliant HIPAA formatted encounter files will be submitted at a document level and line level per the requirements within the System Companion Guide, the 837I and 837P Companion Guide and any other applicable guides. NEMIS creates a unique control number that is used for submissions and tying responses back to the submission. We will leverage the same methodology for the DHH encounter program. The encounter management team works with internal IT partners to schedule file submissions to meet State-specific timeliness requirements.

As required, an attestation to the truthfulness, accuracy and completeness of all encounter data submitted will be included. We will configure our submission to meet the 100,000 encounter claim limitation. If we must exceed the limit, we will seek prior approval.

UnitedHealthcare uses our CareOne platform as our utilization management/prior authorization tool and system of record for all prior authorizations. All inpatient stay authorizations and outpatient service authorizations, for services that require authorization, are recorded there. As specified in 17.8.5, we will provide DHH with weekly encounter data on all prior authorization requests directly from our CareOne platform. The data will be reported electronically to DHH in a mutually agreeable format as specified in the Systems Companion Guide.

Response File Process

NEMIS receives the FI encounter submission response files with acceptance detail and posts a response status. The encounters management team researches all rejected encounters as identified by the denial code list within the Systems Companion Guide. The team partners with functional operating teams, including subcontracted vendors, to resolve and timely resubmit the rejected encounter as replacements, adjustments or voids. If errors are found by DHH or subcontractors that require encounters to be adjusted or voided, we will complete within the 14 day timeline. NEMIS also generates encounter post submission completeness reports that provide our encounters management team with detailed insight into the process with key checkpoints that verify all transactions are balanced and reported.

Encounter Reporting and Tracking

NEMIS logs defects in submissions and generates error reports that allow our encounters management team to analyze and resolve systemic issues, improving the quality of encounters submitted.

On a monthly basis, our encounter management team reviews trend analysis reports tracking the top issues experienced. For the short term, mitigation plans are developed to correct identified issues before the next submission. For the long term, edits are identified and developed to improve future results.

Continuous Quality Improvement

UnitedHealthcare continuously reviews current encounter requirements and processes for opportunities to improve encounter quality. Pended and denied encounter reports are reviewed for trends to identify where new claim edits may increase accuracy and reporting. Additionally, we monitor encounter rejections to identify all providers (including sub-capitated, atypical and non-participating) in need of additional claim billing education. We welcome collaborative work sessions with the State on encounters as our experience shows they are very effective in improving quality.

Meeting the Requirements of 17.8 and the Systems Companion Guide

We have reviewed the Systems Companion Guide and RFP requirements, and we will fully comply with all encounter data submission and reporting requirements in accordance with this RFP.

UnitedHealthcare recognizes accurate, timely and complete encounter data submissions are evidence that we are fulfilling our responsibilities to DHH, allowing use of the data as the foundation for evaluating performance and quality and determining premium payments in the future. We believe accurate encounter data begins with accurate claims. All claims are subject to a series of reviews to ensure we have all the data we need to not only process the claim but produce accurate encounters.

X.4 Describe your methodology for ensuring that claims payment accuracy standards will be achieved. At a minimum address the following in your response:

- The process for auditing a sample of claims as described in Section 17.5 Sampling of Paid Claims;
- Documentation of the results of these audits; and

The processes for implementing any necessary corrective actions resulting from the audit. (10 points)

Our methodology for ensuring claims payment accuracy standards will be achieved includes a cross-functional claims quality assurance program that applies a combination of automated system checks and manual assessments. Our desire to self-monitor, self-report and improve operations underscores our commitment to comply with the requirements in Section 17, including Section 17.5 Sampling of Paid Claims.

Process for Auditing a Sample of Claims as Described in Section 17.5

We have a robust process for monitoring and enforcing claims payment accuracy at all levels, and believe our members can provide great insight into situations that we cannot discover using claims data alone. As we do for some of our Medicaid, Medicare and commercial markets in other states, we will select, at a minimum, a 2 percent stratified sampling of claims encompassing all provider specialties and claim types, and produce Explanation of Benefits

(EOB) notices to the impacted members. The EOB will clearly and simply identify the service provided, the provider of service, the date of service, the amount paid for the service, as well as an explanation for their receipt of the EOB. The explanation will encourage these members to contact our member services representative (MSR) at the toll-free number provided and confirm the EOB accurately describes services they received.

Documentation of the Results of Audits

In accordance with Section 17.5.6, reporting will include the total number of survey notices sent out to members, total number of surveys completed, total services requested for validation, number of services validated, analysis of interventions related to complaint resolution, and number of surveys referred to DHH for further review.

Management and Monitoring Claims Payment Accuracy

To verify adherence to claims processing standards, we use multiple quality audits and programs to monitor claims accuracy and adherence to claims processing standards. Our approach to claims monitoring and quality effort includes pre-disbursement review, post-disbursement review and prevention, including root cause analysis and resolution.

These continuous and comprehensive internal audits are performed by our national business process quality management (BPQM) team, which is separate and independent from claims operations, verifying integrity in the audit oversight process. We include all medical claims in our reports and audit processes. BPQM audit personnel have broad experience in claims processing, possess strong analytical skills and work closely with our local claims department to address issues identified from the audits. This collaboration supports performance improvement by enabling us to make corrections to the system and to provide feedback and mentoring for processors.

We hold our subcontractors to the same high standards for testing and reporting claims payment accuracy. Monthly results are reported to the Delegation Vendor Oversight Committee (DVOC) for oversight purposes.

Additionally, reports with the financial performance metrics and control charts will be distributed to the Louisiana senior leadership team weekly. Monthly reports are automatically generated after audits for the sampled claims are finalized for the month. The reports include monthly quality metrics by platform and by claim processing location. Reports can also be manually generated to obtain details on the defects identified. The claim detail reports will be reviewed monthly by Six Sigma Black Belts and used for defect analysis quality improvement projects.

Achieving Claims Payment Accuracy - Claim Sampling and Reporting System

To maintain a high level of claims payment accuracy, we use our multi-faceted claims management and reporting system to extract a stratified sampling.

System-generated and Smart Audit Master System (SAM) Edit Reviews

- ***Pre-disbursement Review:*** During the claims processing review process, claims are subject to a number of systematic reviews to identify:
  - Unanticipated claim billing patterns
  - Potential questionable billing practices

- Review is conducted by the claim system and will flag a processor to review any suspect claims or concerns
  - Processor is required to review each of these warnings and to apply the appropriate claim processing guidelines to the claim, to determine the appropriate outcome for each claim reviewed

Random Sampling Review

- ***Post-disbursement Review:*** Once claims processing has been completed, we use the SAM system to randomly sample the processed claims. Claim auditors access the selected claims within SAM and review the claims to determine processing accuracy. Our process is outlined below:
  - Review is a stratified and weighted selection of processed claims:
    - Claims are divided into eight categories called strata based upon the dollar amount paid.
    - A fixed number of claims are randomly selected for review.
    - The number of claims selected per strata is based upon the percent of paid dollars per strata. The metrics we produce as part of the quality audit include weighted dollar accuracy, weighted financial accuracy, weighted claim payment accuracy, weighted procedural accuracy and weighted overall accuracy. By using the weighted and stratified approach, our results are a statistically valid representation of the claim processing accuracy of the full population of processed claims with a confidence interval of 95 percent +/- 3 percent.
- Review is conducted daily, and results are tabulated on a monthly basis

Individual Processor Review

- Random sample selection based upon work completed by each individual processor
- Designed to drive individual contributor's accountability
- Ensures processor meets or exceeds quality standards
- Identifies areas of opportunity for quality improvement
- Ensures consistent understanding of claim processing across the organization
- Performed weekly, results scored monthly
- Focused audits are performed for specific problematic topics to identify patterns and root cause:
  - The focused auditing is done as needed, and typically has a limited scope that looks at a narrow slice of our claims
  - Audit could be driven by:
    - Service types
    - Providers that have recently experienced disruptions
    - Any other characteristic/demographic that requires additional review
    - A clinical review of the claims may be requested, based upon initial findings of the review

- Post Training Quality Review program is used to review claims processors' claim payment accuracy and provide post-classroom training to identify training gaps or training opportunities
- Auditor Validation is a program to examine samples of auditors' work to confirm consistency in quality review procedures

In accordance with Section 17.7.2, the minimum attributes to be tested for each claim selected will include the following:

- Claim data correctly entered into the claims processing system
- Claim is associated with the correct provider
- Proper authorization was obtained for the service
- Member eligibility at processing date correctly applied
- Allowed payment amount agrees with contracted rate
- Duplicate payment of the same claim has not occurred
- Denial reason applied appropriately
- Copayment application considered and applied, if applicable
- Effect of modifier codes correctly applied
- Proper coding

Implementing Corrective Actions Resulting from an Audit

In accordance with Section 17.11.1.2, we will provide a written corrective action plan to DHH within 10 business days of receipt of the audit report. Mr. Lirette along with the claims team allocates resources to focus on and correct key issues. When involvement is needed from other departments, cross-functional teams are established to perform analysis and determine corrective action. Remediation activities are presented to our Service Quality Improvement Subcommittee (SQIS), chaired by Mr. Lirette, to verify issues are being addressed and corrected.

Focused contract audits are used to audit contract terms against facility paid claims on a monthly retrospective basis. We perform claim payment accuracy audits by validating system configuration against the contract terms. The contract audits include a review of the accuracy of the claims paid against the new contract installation to catch errors early in the lifecycle of new contract loads. Defect remediation follows Six Sigma remediation processes and triggers additional audits upon resolution.

To verify adherence to claims processing standards, we use multiple quality audits and programs to monitor claims accuracy and adherence to claims processing standards. Our approach to claims monitoring and quality effort includes pre-disbursement review, post-disbursement review and prevention, including root cause analysis and resolution.

We hold our subcontractors to the same high standards for testing and reporting claims payment accuracy. Monthly results are reported to the DVOC for oversight purposes. The DVOC process is described in our response to X.1 above.

UnitedHealthcare will work in close partnership with our Services and Technology division, Optum, in the provision of program integrity services. Our end-to-end process focuses on prospective and retrospective detection, investigation and recovery for a holistic approach to

program integrity. Additional information and details on Program Integrity are contained in Part VIII, Section V. Sophisticated tools and programs ensure the integrity of the claims we will pay. Claims payment and review processes are conducted to assure federal and state specific payment and policy requirements are accounted for within the claims payment and review process.

Part X: Added Value to Louisiana Members, Providers & Employees

Section Y: Value Added to Members

Y.1 Provide a listing, description and conditions under which you will offer value added benefits as described in the RFP Section 6.1.3.

The proposed monetary value of these benefits will be considered a binding contract deliverable. If for some reason, including but not limited to lack of member participation, the aggregated annual per member per month PMPM proposed is not expended the department reserves the right to require the MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.

For each value-added benefit proposed:

- Define and describe the expanded benefit;
- Identify the category or group of Members eligible to receive the expanded service if it is a type of service that is not appropriate for all Members;
- Note any limitations or restrictions that apply to the expanded benefit
- Identify the types of providers responsible for providing the expanded benefit, including any limitations on Provider capacity if applicable.
- Propose how and when Providers and Members will be notified about the availability of such expanded benefits; and
- Describe how a Member may obtain or access the Value-added Service;
- Describe how, you will identify the expanded benefit in administrative data or encounter data. Indicate the PMPM actuarial value of expanded benefits assuming enrollment of 200,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information. The department will work with its contract actuary to independently review any statements of actuarial value.
- Include a statement of commitment to provide the expanded benefits for the entire thirty six (36) month term of the initial contract. (100 points)

In conformity with Section 6.1.3 and the DHH goals to provide cost-effective services and improve member outcomes, we offer a wide array of value-added benefits to Louisiana Bayou Health members. Our proposed value-added benefits and services are estimated to have a monetary value of $3.76 PMPM. We understand this proposed monetary value is considered a binding contract deliverable. We further understand that if for some reason, including but not limited to, lack of member participation, the aggregated annual PMPM value proposed is not expended, DHH reserves the right to require us to provide an alternate benefit of equal value and may conduct a reconciliation for the amount unexpended.

Our core programs and services described throughout this response align with the health care priorities of the state of Louisiana. We recognize the priorities of DHH and offer assurances that these too are priorities for UnitedHealthcare. The priorities as outlined by DHH in section 6.1.3 include:

- Reduction in ER use for non-emergent care
- Improved birth outcomes
- Reduction in obesity, particularly childhood
- Reduction in health disparities

- Improved screening and treatment for communicable diseases
- Improved access to long-term contraceptives
- Improved outcomes for adults with sickle cell disease

Through a combination of health care services, benefits and positive incentives, we ensure the State's priorities are fully addressed. For example, our Healthy First Steps maternity program focuses on maternal wellbeing and adherence to prenatal and postpartum standards of care to achieve improved birth outcomes. We partner with DHH and providers to drive improved birth outcomes through a variety of activities including alignment with DHH's pre-authorization requirements for labor induction prior to 41 weeks and proof of medical necessity for cesarean sections; a focus on screenings for sexually transmitted diseases (STI) throughout the Obstetrics Incentive program and member education regarding the availability of long-acting reversible contraceptives. Programs including Heart Smart Sisters, ENCORE Plus and Together Baton Rouge coupled with the deployment of community health workers allow us to address the social determinants of health and to drive a reduction in health disparities among the diverse citizens of Louisiana.

Building upon our core programs and competencies, we propose the following value-added services to enhance members' physical, behavioral and social wellbeing and to ultimately lead to improved health outcomes. When considering the type and structure of our value-added benefits, we engage our Member Advisory Panel for feedback on additional resources that are deemed valuable from their perspective in supporting the improved health and wellbeing of our members. As demonstrated below, our 16 proposed valued-added benefits align with the following DHH population health priorities:

Reduction in Emergency Department Use

- Adult unlimited visits to in-network PCPs and specialists
- Adult well-visit incentive
- Well-child visit incentive
- Health risk assessment completion incentive
- Certified asthma educator home visit

Improved Birth Outcomes

- Baby Blocks
- Healthy Pregnancy Care Book

Reduction in Obesity

- Weight Watchers
- JOIN for Me Childhood Obesity Program
- Youth recreation program

Reduction in Health Disparities

- Community health worker
- Cell phones for high-risk members

Expanded Benefits

- Adult immunizations
- Adult dental benefit
- Adult vision benefit
- Pain Management for Adults

Additional Health, Safety and Hygiene

- Diabetic screening incentive

The following table provides the detailed information on each of our proposed value-added benefits:

Reduction in Emergency Department Use

Adult Unlimited Visits to In-network Primary Care Physicians and Specialists	
Definition and Description	There are many health issues and disparities in Louisiana Medicaid recipients in the areas of diabetes, obesity, high blood pressure, birth weight, STIs and other conditions. According to DHH's website, the average cost of an ER visit is $1,000, much greater than the cost of a visit to a PCP for the same symptoms. According to the Centers for Disease Control and Prevention (CDC), in 2011, Louisiana ranked third in the nation in per capita ER use. Routine visits to members' PCPs can help build critical relationships between the member and their PCP. We believe that preventive care is a key to mitigating any potential health risks and reducing ER visits. In addition, timely access to appropriate specialists is a key to effectively diagnosing and treating certain conditions. To help combat health disparities, improve access to care and reduce unnecessary ER usage, we are offering members unlimited visits to UnitedHealthcare contracted PCPs and specialists if deemed medically necessary by their PCP.
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare and over the age of 21 are eligible.
Limitations or Restrictions	This enhanced benefit is limited to visits with UnitedHealthcare contracted providers and specialists if deemed necessary.
Type of Provider or Other Person Responsible for Service, including limitations	UnitedHealthcare contracted providers and specialists will provide the service. Visits to non-contracted providers and specialists are excluded, unless authorized.

Adult Unlimited Visits to In-network Primary Care Physicians and Specialists	
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CST ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider relations visits to provider offices throughout the year
How Members Obtain Service	Members will contact the PCP or specialist to schedule appointments. The providers will be reimbursed according to contractual arrangements.
Identification of Service in Administrative Data or Other Documentation of Service	We will identify utilization of this service through claims data and in encounter data submitted to the State's fiscal intermediary (FI).
[redacted]	[redacted]
Benefits available for the entire thirty-six (36) month term	Yes

Adult Well-Visit Incentive	
Definition and Description	Establishing an ongoing relationship with a PCP is an effective way to maintain good health, receive preventive care, screen for behavioral health needs and reduce ER visits. To encourage members on their journey to good health we offer healthy rewards as positive reinforcement. For members who complete a PCP visit within 90 days of enrollment, we will provide a $20 gift card. We will use claims data to identify when the qualifying service has been completed. Upon completion of the qualifying service, the reward will be sent **without** requiring the member to complete a form or request the reward.
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare and over the age of 21 are eligible.
Limitations or Restrictions	Members must be over the age of 21 and see an in-network PCP within 90 days of enrollment. Visits to non-contracted providers are excluded. Limited to one gift card per year.

Adult Well-Visit Incentive	
Type of Provider or Other Person Responsible for Service, including limitations	UnitedHealthcare contracted providers will provide this service.
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider services visits to provider offices throughout the year
How Members Obtain Service	Members schedule and complete their visit with their in-network PCP within 90 days of enrollment. A gift card will be mailed to the address on file.
Identification of Service in Administrative Data or Other Documentation of Service	We will use claims data to identify members who complete the visit within 90 days. Cost of gift cards will be tracked in administrative data.
[redacted]	[redacted]
Benefits available for the entire thirty-six (36) month term of the initial contract.	Yes

Well-Child Visit Incentive	
Definition and Description	Well-child visits are an important part of a child's health maintenance. Periodic well-child visits can alert parents to developmental delays, proactively manage or prevent childhood conditions such as asthma, diabetes or obesity; provide valuable parenting advice and screen for behavioral health needs. We believe this expanded benefit may help deter critical care, such as hospitalizations or ER visits. To encourage parents to bring their children in for these visits we are offering a $20 gift card for one well-child visit each year between the ages of 1 and 17. We will use claims data to identify when the qualifying service has been completed. Upon completion of the qualifying service, the reward will be sent **without** requiring the member to complete a form or request the reward.
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare and between the ages of 1 and 17 are eligible.
Limitations or Restrictions	Members under the age of 1and older than the age of 17 are not eligible. Visits to non-contracted providers are excluded. Limited to one gift card per year.
Type of Provider or Other Person Responsible for Service, including limitations	UnitedHealthcare contracted providers will provide this service.
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider services visits to provider offices throughout the year
How Members Obtain Service	Members or their caregiver schedule and complete a well-child visit with their in-network PCP.
Identification of Service in Administrative Data or Other Documentation of Service	We will use claims data to identify members who complete the annual well-child visit. Cost of gift cards will be tracked in administrative data.

Well-Child Visit Incentive	
[redacted]	[redacted]
Benefits available for the entire thirty-six (36) month term of the initial contract.	Yes

Health Risk Assessment Completion Incentive	
Definition and Description	The health risk assessment (HRA) is the starting point to understanding the health care needs of the individuals we serve. The HRA can help make us aware of needs for care coordination, behavioral health services, disease management, preventive services and refer to community services that can help close gaps in care or overall wellness. To promote the completion of the HRA within 90 days of enrollment, we will provide a $10 gift card for members who qualify. ▪ Members may complete the HRA: • Telephonically during welcome call • Electronically through *uhccommunityplan.com* ▪ Members who complete the HRA within 90 days of enrollment will be mailed a gift card to the address on file.
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare who complete the HRA within 90 days of enrollment.
Limitations or Restrictions	One gift card provided per member upon HRA completion after enrollment.
Type of Provider or Other Person Responsible for Service, including limitations	Members will complete the UnitedHealthcare HRA through one of the ways described above.

Health Risk Assessment Completion Incentive	
Provider and Member Notification of Service (Method and Timeframe)	All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider services visits to provider offices throughout the year.
How Members Obtain Service	Can be done in the three ways noted above. Following the completion of the HRA, a gift card will be mailed to the members address on file.
Identification of Service in Administrative Data or Other Documentation of Service	We will generate a report from CareOne to identify members who have completed the HRA and mail the gift card to the member to the address on file. Cost of gift cards will be tracked in administrative data.
[redacted]	[redacted]
Benefits available for the entire thirty-six (36) month term of the initial contract.	Yes

Certified Asthma Educator Home Visit	
Definition and Description	According to the DHH website, 44 percent of children with asthma in Medicaid visited the ER last year in Louisiana. To help address and better manage asthma for the individuals we serve, we will offer one visit per year with a certified asthma educator. Certified asthma educators are individuals with expertise in the evaluation of person-specific asthma triggers for severe/moderate asthmatics. Educators can do a home assessment to educate members on how to decrease environmental impact on their asthma, such as using hypo allergenic air filters. They also provide education for the member/family in reducing the triggers in the home, while offering specific guidelines for their individual asthma plan. While conducting their home assessments, asthma educators will identify issues such as mold.

Certified Asthma Educator Home Visit	
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare who are diagnosed with moderate to severe asthma and are unable to control their asthma with appropriate medical interventions, as evidenced by reoccurring hospitalizations and ER visits are eligible to receive one home assessment per year.
Limitations or Restrictions	This benefit is limited to one encounter per eligible member per calendar year, based upon referral from PCP, case manager or medical director.
Type of Provider or Other Person Responsible for Service, including limitations	UnitedHealthcare will contract with certified asthma educators to provide the home assessment. Limited to in-network asthma educators.
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider services visits to provider offices throughout the year.
How Members Obtain Service	The need for a home assessment is determined through communications with PCPs, care managers and our medical director in multidisciplinary rounds. In addition, providers may request evaluation for eligible asthmatics.
Identification of Service in Administrative Data or Other Documentation of Service	We will identify utilization of this service through claims data and in encounter data submitted to the State's FI.
[redacted]	[redacted]
Benefits available for the entire 36-month term	Yes

Improved Birth Outcomes

Baby Blocks	
Definition and Description	Baby Blocks offers a unique approach to achieving improved health outcomes for pregnant and postpartum women and their babies. Through the dual appeal of an interactive game interface and attractive rewards, Baby Blocks gets mothers and infants into their providers' offices on a regular basis, resulting in improved quality of care and higher member satisfaction. Baby Blocks is a program that reminds and rewards members for attending appointments during their pregnancy and into the first 15 months of their baby's life. The program uses mobile-optimized engagement tools, including an easy enrollment process, appointment reminders and brief health tips. Eight incentives are delivered to women who achieve health care goals during the 24-month program. Members can choose between two practical items at each stage: ▪ ***Baby Blocks enrollment:*** Durable, black diaper bag or $20 gift card ▪ ***24 week prenatal:*** Bath spout cover or teething rattle with mirror ▪ ***32 week prenatal:*** First aid kit or tabletop toy ▪ ***Birth:*** Digital thermometer or rubber duck bath thermometer ▪ ***Postpartum visit:*** Fisher Price sorting blocks or $20 gift card ▪ ***Six-month well-child:*** Feeding set or dental care set ▪ ***Lead screening:*** Childproofing kit or *Goodnight Moon* board book ▪ ***15-month well-child:*** Shower/bath accessories or soft puzzle
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare who are pregnant or new mothers.
Limitations or Restrictions	This program is only available to pregnant and new mothers. Members are eligible for rewards following enrollment in the program. No retroactive rewards are provided.
Type of Provider or Other Person Responsible for Service, including limitations	We partner with our business associate BI Worldwide to administer this program.

Baby Blocks	
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider services visits to provider offices throughout the year.
How Members Obtain Service	Once enrolled in the program, individuals will track their progress in the Baby Blocks application, available online and on mobile devices. After each reward level is obtained, they will select their prize, which is distributed via mail.
Identification of Service in Administrative Data or Other Documentation of Service	Our business associate BI Worldwide will track utilization of the program and will be identified in our administrative data.
[redacted]	[redacted]
Benefits available for the entire thirty-six (36) month term of the initial contract.	Yes

Healthy Pregnancy Care Book	
Definition and Description	Education is a key to success and it is our intent for any pregnant Bayou Health member to have a healthy, informed pregnancy. As such, we will mail a pregnancy care book ("What to Expect When Expecting") to all pregnant members. This book is an additional resource for our pregnant members and new parents. It provides important information about baby care and healthy pregnancies; thereby increasing the knowledge of pregnant mothers and parents and promoting the safety, health and wellbeing of the babies and mothers.
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare who are pregnant and new parent Bayou Health members.
Limitations or Restrictions	Limited to pregnant and new parent Bayou Health members. One book per member in a 12-month period.

Healthy Pregnancy Care Book	
Type of Provider or Other Person Responsible for Service, including limitations	UnitedHealthcare will mail the book to the address on file.
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider services visits to provider offices throughout the year
How Members Obtain Service	Members will automatically receive the book in the mail upon identification of a pregnancy using enrollment and claims data.
Identification of Service in Administrative Data or Other Documentation of Service	We will track the books mailed in administrative data. In addition, we note the member has received the book in CareOne, our care management program.
[redacted]	[redacted]
Benefits available for the entire 36-month term	Yes

Reduction in Obesity

We are very supportive of DHH's Well-Ahead health initiative to improve the wellbeing of all Louisianians and recognize that obesity is an extremely prevalent health issue in Louisiana and increases the likelihood of many diseases such as heart disease, type 2 diabetes, certain types of cancer and osteoarthritis. In addition, obesity can reduce members' ability to be physically active and reduce their quality of life. To support members in achieving their weight loss goals and overall wellbeing, we will offer the following value-added benefits:

Weight Watchers	
Definition and Description	We offer enrollment in the Weight Watchers program for qualified members. Members will receive vouchers to attend official Weight Watchers meetings where they will learn valuable skills about healthy eating and weight loss.
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare who have a referral from their PCP and are over the age of 12 are eligible for this program.

Weight Watchers	
Limitations or Restrictions	Members must be above the age of 12 and have a referral from their PCP to be eligible. The maximum annual benefit is 10 vouchers.
Type of Provider or Other Person Responsible for Service, including limitations	UnitedHealthcare will partner with Weight Watchers to provide this incentive.
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider services visits to provider offices throughout the year
How Members Obtain Service	Following provider referral, members will contact our member services department. Vouchers will be mailed to the address on file.
Identification of Service in Administrative Data or Other Documentation of Service	We will track the vouchers issued in administrative data.
[redacted]	[redacted]
Benefits available for the entire thirty-six (36) month term of the initial contract.	Yes

JOIN for ME[SM] – Childhood Obesity Program	
Definition and Description	One dilemma for parents and pediatricians is that few childhood obesity programs are available. Most existing programs are limited to tertiary care centers, available only to research participants or adults, or have costs or access barriers that are prohibitive. JOIN for ME is a childhood obesity program developed by UnitedHealthcare that has proven to be an effective and accessible treatment of childhood obesity. This intervention program provides affordable and accessible obesity counseling to children who struggle with extra weight. Through a group intervention model, where a child and caregiver participate together, the JOIN for ME program underscores the importance of cultivating a healthier environment and healthier behaviors at home with the entire family. If the child completes the community-based pediatric obesity program (attends 12 of 16 in-person sessions), they will be eligible for a $50 gift card that will be distributed during the final class. The program supports children and their families in building skills to effectively manage eating and activity patterns to achieve a healthier weight.
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare who are ages 6 through 17 who are above the 85th percentile for body mass index (weight-to-height ratio) and in general good health. General good health means that the child or teen is able to regularly attend a weekly class, participate in group discussions with other kids/teens and has not received or is in need of a clinically higher level of nutritional counseling from their doctor.
Limitations or Restrictions	Limited to members ages 6 through 17 who are above the 85th percentile for body mass index (weight-to-height ratio) and are in general good health. To receive the $50 incentive the child must complete the obesity program (by attending 12 of the 16 classes). Classes are offered in GSAs A and B. The intended class locations are in Baton Rouge, New Orleans, North Shore, Lafayette and Thibodaux.
Type of Provider or Other Person Responsible for Service, including limitations	UnitedHealthcare will administer this benefit.

JOIN for ME[SM] – Childhood Obesity Program	
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider services visits to provider offices throughout the year
How Members Obtain Service	We will identify eligible members through PCP and case manager referrals. Members may also self-identify by calling our member services center. Members who call will have an appointment scheduled with their PCP to assess their eligibility.
Identification of Service in Administrative Data or Other Documentation of Service	We will identify service through JOIN for ME engagement specialists who enroll members into the program. Reports of members who successfully complete the program will be generated at the end of each session. Gift cards issued will be tracked in administrative data.
[redacted]	[redacted]
Benefits available for the entire thirty-six (36) month term of the initial contract.	Yes

Youth Recreation Programs	
Definition and Description	Involvement with youth organizations can help children build relationships in the community and provide social structure that is vital for their growth and development. To support these children, we will provide membership dues to the Boys and Girls Club program of Louisiana, for all members under the age of 19. If Boys and Girls Club is not available, we will find an alternate youth organization for the child. Membership in these youth organizations may also include summer camps and athletic leagues to bolster confidence and promote a healthy lifestyle.
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare who are under the age of 19.

Youth Recreation Programs	
Limitations or Restrictions	Does not include special programs offered outside of the basic membership (some programs may be limited to first come, first served registration).
Type of Provider or Other Person Responsible for Service, including limitations	UnitedHealthcare through youth organizations such as Boys and Girls Club.
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider services visits to provider offices throughout the year
How Members Obtain Service	Members contact their local Boys and Girls Club and show their UnitedHealthcare ID card for complimentary membership. If no Boys and Girls Club is available in the area the member lives, they should contact member services to obtain information for the alternate youth organization in their area.
Identification of Service in Administrative Data or Other Documentation of Service	We will receive participation reports from the Boys and Girls Club and alternate youth organizations on a monthly basis. We will track the expense in administrative data.
[redacted]	[redacted]
Benefits available for the entire thirty-six (36) month term of the initial contract.	Yes

Reduction in Health Disparities

Community Health Worker Program	
Definition and Description	Our Community Health Worker program brings coordinators to local communities and the homes of members, where they are able to answer questions and provide assistance. Community health workers come directly from local neighborhoods and are able to assist members in accessing their PCP, obtaining transportation to appointments, connecting with services in the community and direct and assist expectant mothers with choosing a PCP for their child.
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare who are contacted by the community health worker are eligible. Members in the "most vulnerable" category who have less intensive medical or behavioral health risk or who have been difficult to reach (lower 70 percent of the top 5 percent of members by cost)
Limitations or Restrictions	Engagement with a community health worker is limited to members identified as most vulnerable.
Type of Provider or Other Person Responsible for Service, including limitations	Community health workers contracted or employed by UnitedHealthcare.
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal Periodic provider services visits to provider offices throughout the year
How Members Obtain Service	Members who qualify for the community health worker will be contacted via phone or in person by the community health worker. Members may also be connected with a community health worker through case management. Finally, members may also contact our member services department to be connected to a community health worker.
Identification of Service in Administrative Data or Other Documentation of Service	Visits with the community health worker will be documented in CareOne, our medical management system. Salaries or contract worker fees will be tracked in administrative data.

Community Health Worker Program	
[redacted]	[redacted]
Benefits available for the entire thirty-six (36) month term	Yes

Cell Phones for High Risk Members	
Definition and Description	To support DHH's goal of providing improved access to care, a cellphone will be supplied to members who receive high-risk case management or high-risk pregnancy case management if they do not have reliable access to a telephone. The case manager will review the member's medical complexity and issue a cellphone if the member's condition warrants. The purpose of the cellphone initiative is to make sure members have access to UnitedHealthcare, 911, the PCP office and MyNurseLine, and that our members have access to reach out for help in the event of emergencies or difficulty accessing care.
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare who are enrolled in high-risk case management (acute asthma, congestive heart failure (CHF), chronic obstructive pulmonary disorder (COPD), acute diabetes, organ transplant, acute obesity) or at-risk pregnant members without reliable telephone access.
Limitations or Restrictions	Members may only use phones for health-related services, such as to make calls to UnitedHealthcare, providers or 911. Eligible members will receive one phone per household per contract period and have a limit of 250 minutes a month, inclusive of voice mail, caller ID, long distance and call waiting. Members will have unlimited texting.
Type of Provider or Other Person Responsible for Service, including limitations	UnitedHealthcare will provide the cell phones

Cell Phones for High Risk Members	
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider services visits to provider offices throughout the year
How Members Obtain Service	A member will be referred to the enrollment process by their case manager. Once successfully enrolled, the phone will be mailed to the member's address on file.
Identification of Service in Administrative Data or Other Documentation of Service	We will document the distribution of phones in CareOne and in administrative data.
[redacted]	[redacted]
Benefits available for the entire 36-month term	Yes

Expanded Benefits

Adult Immunizations	
Definition and Description	Traditionally, vaccines have been associated with protecting young children, but far too many adults become ill, disabled or die each year from diseases that could easily have been prevented by vaccines. Vaccines not only prevent disease in the people who receive them but often create "herd immunity," meaning that even unvaccinated individuals are at lower risk of disease if most of their community is immunized. Everyone from young adults to older adults can benefit from immunizations. To help increase the rate of flu and pneumonia vaccines in adults in Louisiana, we will provide flu vaccines to adults age 21 and over and pneumonia vaccines and boosters to adults 65 or older or 19 or older with certain medical conditions based upon CDC recommendations.
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare who are over the age of 21.

Adult Immunizations	
Limitations or Restrictions	Limited to members over the age of 21. We will limit the pneumococcal polysaccharide vaccine (PPSV23) to adults 65 or older or 19 or older with certain medical conditions based upon CDC recommendations. Benefits must be obtained through contracted providers.
Type of Provider or Other Person Responsible for Service, including limitations	UnitedHealthcare contracted providers will provide this service.
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal Periodic provider services visits to provider offices throughout the year
How Members Obtain Service	Members will schedule an appointment with their in-network provider to obtain this service. Services may be available at some providers without an appointment.
Identification of Service in Administrative Data or Other Documentation of Service	We will identify utilization of this service through claims data and in encounter data submitted to the State's FI.
[redacted]	[redacted]
Benefits available for the entire 36-month term	Yes

Adult Dental Benefit	
Definition and Description	We recognize the importance of preventive and routine dental services to the overall health of our members. In our experience in Bayou Health since 2012 we have found that a number of members visit the ER with tooth pain. Because they do not have dental benefits, pain management, often obtained through the ER is their only course of action. We believe that offering a real alternative that addresses the root cause rather than the symptoms will not only decrease ER utilization, but improve quality of life for our adult members. This benefit provides routine exams, x-rays, cleanings, fillings and extractions for UnitedHealthcare Bayou Health members who are ages 21 and older.
Category of Members Eligible	Members 21 and older without Medicaid coverage for dental services are eligible to receive the service.
Limitations or Restrictions	Limited to members age 21 and older. Must use in-network providers. Benefit maximum of $500 per year.
Type of Provider or Other Person Responsible for Service, including limitations	Contracted dental benefit providers will provide this service.
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker ▪ We notify members of the dental benefit through provider newsletters at least annually. Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider services visits to provider offices throughout the year
How Members Obtain Service	Members make an appointment with a contracted dental provider to obtain services. Members may access our provider directory at *myuhc.com*, call the toll-free number listed on the back of their ID card or request a printed directory for assistance in selecting a dentist from an approved list.
Identification of Service in Administrative Data or Other Documentation of Service	We will identify utilization of this service through claims data and in encounter data submitted to the State's FI.
[redacted]	[redacted]

Adult Dental Benefit	
Benefits available for the entire 36-month term	Yes

Adult Vision Benefit	
Definition and Description	We believe that providing additional vision benefits to adult members in Louisiana not only will benefit their overall quality of life and independence, but also enable early detection of other diseases like diabetes, multiple sclerosis and high blood pressure. We will provide members over the age of 21 with additional vision services to complement the limited Medicaid vision benefit. These services include: ▪ One routine eye exam every two years ▪ $100 allowance for frames/lenses every two years
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare who are over the age of 21.
Limitations or Restrictions	The following limitations are in place for these services: ▪ Must be obtained within the subcontracted vision provider network. ▪ Material and frame options are covered in full up to a maximum benefit of $100 per year. ▪ For replacement frames or lenses, prior authorization is required and cannot be used for a second or "spare." ▪ If the member chooses the contact lens program, the benefit will cover the fitting/evaluation fees, contacts (disposable contacts up to four boxes, depending on prescription and plan selected), and up to two follow-up visits and up to $105.00 allowance.
Type of Provider or Other Person Responsible for Service, including limitations	We will contract with March Vision to provide additional vision services. There are no anticipated limitations on provider capacity.
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider services visits to provider offices throughout the year

Adult Vision Benefit	
How Members Obtain Service	Members may self-refer to any contracted vision provider or may find out how to access services by calling our member services department. Members may also ask their contracted vision provider to obtain prior authorization for replacement glasses and lenses.
Identification of Service in Administrative Data or Other Documentation of Service	We will identify utilization of this service through claims data and in encounter data submitted to the State's FI.
[redacted]	[redacted]
Benefits available for the entire 36-month term	Yes

Pain Management for Adults	
Definition and Description	Back pain is second only to headaches as the most common neurological ailment in the United States. Based upon the DHH quarterly review, 38 percent to 42 percent of ER visits in Louisiana are low level. Of these, back pain is the leading diagnosis. Holistic management of back pain through regular visits with a chiropractor may proactively manage and improve lower back pain. In some cases, a visit to the chiropractor can remove or reduce the need for painkillers and may reduce ER visits for back pain. One way to proactively manage and improve lower back pain is through chiropractic care. We will offer six visits per calendar year to an in-network chiropractor.
Category of Members Eligible	All UnitedHealthcare Bayou Health members 21 and over are eligible.
Limitations or Restrictions	Limited to members over the age of 21 and six visits per calendar year to an in-network chiropractor.
Type of Provider or Other Person Responsible for Service, including limitations	UnitedHealthcare contracted chiropractors will provide this service.

Pain Management for Adults	
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker ▪ We notify members of the dental benefit through provider newsletters at least annually. Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider services visits to provider offices throughout the year
How Members Obtain Service	Individuals will contact the in-network chiropractor to schedule appointment.
Identification of Service in Administrative Data or Other Documentation of Service	We will identify utilization of this service through claims data.
[redacted]	[redacted]
Benefits available for the entire 36-month term	Yes

Additional Health, Safety and Hygiene

Diabetic Screening Incentive	
Definition and Description	Bayou Health Diabetes and Obesity Report from January 2014 reveals that diabetes affects a higher portion of Louisiana citizens than the national average (11.8 percent compared to 9.5 percent). One way to control the development of diabetes-related complications is to regularly monitor glucose and cholesterol levels. Our diabetes program provides an incentive to all diabetic members that have an HbA1c and LDL-C screening within 90 days of enrollment. Members who complete their HbA1c labs and LDL-C screening within 90 days of enrollment are eligible for a $50 voucher toward products from a catalog of over-the-counter items. The catalog includes personal health care items geared to the diabetic population not otherwise available through Medicaid, such as over-the-counter vitamins and supplements, bath safety items, aspirin and other items.
Category of Members Eligible	All Bayou Health participants enrolled with UnitedHealthcare who are age 21 and over are eligible for this incentive.
Limitations or Restrictions	Members must complete their labs within 90 days of enrollment and must complete both the HbA1c and LDL-C tests. The voucher will expire six months after they receive it.
Type of Provider or Other Person Responsible for Service, including limitations	UnitedHealthcare contracted providers will conduct the screening.
Provider and Member Notification of Service (Method and Timeframe)	Members: All UnitedHealthcare members will receive notifications through several communication channels: ▪ *Member Handbook*, available 24 hours a day seven days a week through *uhccommunityplan.com*; an overview is mailed to the member upon enrollment; available in print upon request ▪ *HealthTalk* – member newsletter, mailed quarterly ▪ *myuhc.com* – our secure member website, available for self-service 24 hours a day, seven days a week ▪ Member services staff, available 7 a.m. – 7 p.m. CT ▪ Case management/community health worker Providers: All contracted providers receive notification of the benefits and billing requirements through various methods: ▪ Quarterly newsletters ▪ Monthly Webinars ▪ *Provider Administrative Guide* ▪ BayouCloud Provider Portal ▪ Periodic provider services visits to provider offices throughout the year
How Members Obtain Service	Members will complete the required screenings by making an appointment with their in-network PCP. The catalog and voucher will be mailed to the address on file.
Identification of Service in Administrative Data or Other Documentation of Service	We will identify eligible members through claims data and track the product expense through administrative data.
[redacted]	[redacted]

Diabetic Screening Incentive	
Benefits available for the entire 36-month term	Yes

UnitedHealthcare's Actuarial Statement

Please refer to our Actuarial Statement included as attachment Y.1 Statement of Commitment, which was prepared by UnitedHealthcare's preparing actuary, Tatyana Kotlovskiy, who is a member of the American Academy of Actuaries and certifies the accuracy of the PMPM actuarial values of our expanded benefits.

Section Z: Value Added to Providers

Z.1 Provide a listing, description and conditions under which you will offer value added incentives or enhanced payments to providers in accordance with Section 9.8 of the RFP.

The proposed monetary value of these incentives and/or enhanced payments will be considered a binding contract deliverable. If for some reason, including but not limited to lack of provider participation or performance, the aggregated annual per member per month PMPM proposed is not expended the department reserves the right to require the MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.

For each value-added incentive proposed:

- Define and describe the provider incentives or expanded payments and associated measures of performance;
- If not applicable to all providers; identify the category or group of providers eligible to participated in the incentive or receive enhanced payments;
- Note any limitations or restrictions that apply to the incentives or enhanced payments;
- Describe how and when Providers and Members will be notified about the availability of such expanded benefits; and
- Describe how provider input and feedback will be used to realign incentives as appropriate.
- Describe how you will identify the associated payments in administrative data or encounter data.
- Indicate the PMPM actuarial value of the proposed provider incentives based on an enrollment of 250,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information. The department will work with its contract actuary to independently verify any statements of actuarial value.
- Include a statement of commitment to provide the expanded benefits for the entire thirty six (36) month term of the initial contract.

Appendix PP must be submitted as part of the proposal. (100 points)

UnitedHealthcare shares DHH's vision for value-based contracting (VBC) partnerships that:

- Encourage closure of gaps in care
- Improve quality outcomes for Bayou Health members
- Reduce avoidable medical expenses

In the development of our VBC programs we reviewed and agree to comply with all specifications and requirements outlined in Section 9.8. Under the direction of CEO April Golenor, we examined UnitedHealthcare's national best practices to determine what programs best would serve the needs of Bayou Health members and providers.

With DHH approval we propose to implement a total of **six provider** incentive models for PCPs, OB/GYNs, hospitals, physician hospital organizations (PHOs) and pharmacists with the goal of improving the patient experience and quality of care while remediating avoidable medical expense and reducing total cost of care. Our ultimate goal is to deliver the highest quality health care to all Bayou Health members while transforming the way providers are reimbursed for health care services.

The comprehensive programs that follow show our commitment to plan-provider partnerships in improving outcomes for all stakeholders in Bayou Health. These values of the enhanced payment and incentive expenditures outlined here are actuarially estimated to be $3.75pmpm.

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Notifying providers about the availability of expanded benefits

Our models are deployed based on quantitative and qualitative evaluations of where providers are across the reimbursement risk and clinical integration continuum. In addition, for those providers being considered for shared savings/shared risk models we evaluate their readiness using a survey that captures, including but not limited to, organizational structure, operational sophistication and total cost of care/population health experience with other payers. We continuously review our network for providers who meet the eligibility requirements for our VBC programs. Once identified, we educate them about our portfolio of programs and work together to determine what model is appropriate. If a provider group approaches us about a value-based payment models, we evaluate that group for eligibility.

During the planning phase of this proposal, our leaders in Louisiana consulted with local providers and sought feedback in the design of these programs. We received valuable information about their current experiences with health plan incentive programs and recommendations about program design, measures and targets.

In addition, we will evaluate provider performance throughout the course of the agreement and in a collaborative manner decide if a) the performance metrics were too stringent or too simple and need to be adjusted or b) if the provider needs to be moved up or down the continuum – in both cases we are amenable to making adjustments off-cycle. Our leadership and staff will also

meet regularly with providers who are participating in our incentive programs and engage in collaborative discussions about ideas for improvement or changes to the models. Finally, we will discuss the programs and seek feedback in our Provider Advisory Committee meetings.

UnitedHealthcare offers a balanced, collaborative approach that assists providers in developing the necessary infrastructure to provide holistic patient care, offers real rewards for improving quality and efficiency performance, and ultimately results in both ***healthier patients and healthier providers.*** We will provide regular reporting on interim performance and collaborate with providers to make real-time adjustments to ensure providers have the tools necessary to support maximum performance possible. Achievement of the goals set is in the best interest of all stakeholders and we will work diligently to support providers in this endeavor.

Notifying Members about the Availability of Expanded Benefits

Upon request, members can receive information about provider incentive programs. Members are informed about their right to receive information via our member portal and from the *Member Handbook*.

Identification of Associated Payments

We will provide **regular reporting** to participants on interim performance and will perform an interim calculation six months into the program whereupon we will make an interim payment of 75 percent of the incentive earned. At the end of the reporting period we will perform a final reconciliation and payment of incentive earned. These payments **will be included in encounter data submitted to the State's fiscal intermediary.**

Summary of Targeted Providers, Members and Total Cost of Care

These comprehensive programs will span:

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PMPM Actuarial Value of Proposed Benefits

We understand that the proposed actuarially estimated monetary value of $3.75 PMPM is considered a binding contract deliverable. We further understand that if for some reason, including but not limited to lack of provider participation or performance, the aggregated annual per member per month amount of $3.75 proposed is not expended the department reserves the right to require us to provide an alternate benefit of equal value and/or may conduct a

reconciliation for the amount unexpended. Finally, we commit to provide these expanded benefits for the entire 36-month term of the initial contract.

Actuarial Certification

Please find the statement from our preparing/consulting actuary, Tatyana Kotlovskiy, who is a member of the American Academy of Actuaries certifying the accuracy of this information in Attachment Z.1-2_Statement of Commitment.

Section AA: Value Added to Louisiana Employees

AA.1 Describe the workplace wellness program and employee incentives you will have in place for your Louisiana-based employees within 3 months from the effective date of the contract. Include incentives for participation. Program components, and expected results.

The proposed annual monetary expenditure for this program and will be considered a binding contract deliverable. If for some reason, including but not limited to lack of employee participation, the proposed annual expenditure is not expended the department reserves the right to require the MCO to provide an alternate employee wellness benefit of equal value and/or may conduct a reconciliation for the amount unexpended.

For each value-added incentive proposed:

- Define and describe the wellness program/employee incentives and associated measures of performance;
- If not applicable to all employees; identify the category or group of employees eligible to participated in the incentive or receive enhanced payments;
- Note any limitations or restrictions that apply to incentives or enhanced payments;
- Describe how and when employees will be notified about the availability of such programs/incentives; and
- Describe how employee input and feedback will be used to realign incentives as appropriate.
- Describe how you will identify the associated payments in administrative data.
- Indicate the total annual expenditures proposed for each of the three (3) contract years.

Include a statement of commitment to provide these expenditures for this purpose for the entire thirty six (36) month term of the initial contract. (25 points)

UnitedHealth Group's mission of helping people live healthier lives is reflected in its enterprise-wide commitment to employee health and wellness. In alignment with UnitedHealth Group's commitment, we provide our Louisiana employees with resources to make health and wellness a priority in their lives. We currently provide an extensive workplace wellness program and employee incentives for our Louisiana-based employees and will continue to do so within three months of the effective date of the contract. **Our Baton Rouge and Metairie offices are designated level 2 WellSpots** through the Well-Ahead Louisiana Initiative further promoting employee wellness including support for tobacco-free and breastfeeding-friendly workplaces.

Workplace Wellness at UnitedHealthcare Community Plan

Figure 72: Walking to Stay Active: A group of Louisiana employees and their family members participate in an annual walk for the American Heart Association.

Our employees are critical to the success of the Bayou Health program. As a premier health care company, we truly believe in helping people achieve better health outcomes. We invest in the physical, cognitive and psychological wellbeing of our employees with the understanding that the wellbeing of our workforce is directly related to our ability as an organization to innovate and successfully serve our members.

Working for a large managed care organization does not exempt our employees from having health issues and struggles of their own. Our employees, their spouses and families face the same health concerns as

our members and customers such as managing their weight, quitting smoking or living with chronic diseases. This is the reason our organization continues to encourage employees to manage their health and the health of their families through our extensive range of workplace wellness programs, services and employee incentives.

Employees Encouraging Employees to Lead Healthier, Active Lives

Our programs are not the only promoters of wellness at UnitedHealthcare. Our Louisiana employees also promote wellness by encouraging each other to maintain healthy lifestyles, holding each other accountable and participating in wellness activities together. Here are a few recent examples:

- Our Louisiana leadership team has been working on weight management. During the last two years, the team lost more than 135 pounds combined.
- More than 10 Louisiana employees recently joined Weight Watchers. The new program participants hold weekly meetings at the office for program support and encouragement.
- Employees in our Metairie office joined together to negotiate a reduced rate at the fitness facility in our office building.
- Several employees participate in the Ride 2 Recovery, an annual, multiple-day cycling event that covers 50 to 70 miles a day and spans 350 to 450 miles total in conjunction with our social responsibility initiatives.

Figure 73: Louisiana employees participate in the Ride 2 Recovery cycling event in support of our country's wounded veterans and healing heroes.

One of the Best Employers for Healthy Lifestyles – Platinum Award

UnitedHealth Group recently received a **Platinum award as one of the *Best Employers for Healthy Lifestyles*®** from the National Business Group on Health (NBGH). This is the fourth consecutive year UnitedHealth Group has been honored with a Platinum award for our commitment to promoting healthy work environments and encouraging employees to live healthier lives.

This award is attributable to the robust wellness programs we offer employees and the positive results we have achieved since implementing our health incentive program, [redacted]

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Other Incentive Employee Wellness Programs

In addition to Your Rewards for Health, our Louisiana employees are eligible for other health and wellness programs that are offered to all UnitedHealth Group employees. These programs include:

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Details of these programs are included in the tables below:

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Workplace Wellness Programs

UnitedHealthcare offers a vast array of programs that promote workplace wellness. We are proud of the support we provide to engage and encourage employees to live our values. Employees are notified of the wellness programs through a variety of mechanisms including email, printed materials, staff meetings and benefit education meetings.

Figure 75: Wellness and Culture Corner is our office health and wellness station featuring fresh fruit and other helpful tips provided in both Louisiana office locations.

We measure the success of our wellness programs through:

- Employee participation in wellness programs
- Increase in employee participation
- More engaged employees in health decisions
- Health status target: maintained/improved health risks for the population

Employees are encouraged to provide feedback through the wellness committee. The wellness committee then determines what improvements and changes will be made. In addition, feedback is captured by managers and during staff meetings. We also participate in Benchmark on National Business Group on Health (a large employer industry trade association focused on benefits). For the fourth year in a row, **UnitedHealthcare was awarded "Best Employer for Healthy Lifestyles"** by this group.

Well-Ahead Louisiana

In alignment with the State of Louisiana's Well-Ahead Louisiana initiative, our wellness programs foster employee engagement and ownership of their own health and wellbeing. Well-

Ahead Louisiana designates healthy places around the State that voluntarily champion and embrace health and wellness. The program is a state-wide effort to partner with local organizations to encourage Louisiana citizens to take more control and ownership of their health. Well-Ahead encourages organizations and individuals to make small healthy changes to the spaces where Louisiana residents spend most of their time.

This initiative further establishes voluntary healthy living designation criteria for organizations, businesses, schools, restaurants and other groups to improve health and wellness outcomes for Louisiana residents. **Our Baton Rouge and Metairie offices are level 2 designated WellSpots,** promoting employee wellness while supporting tobacco-free and breastfeeding-friendly workplaces**.**

As one example of actions we have taken to improve employee health and wellness outcomes, our Louisiana leadership team made a decision to remove the snack vending machine from the office and replaced it with fresh fruit at no charge to employees. Our Wellness and Culture Corner is located in the break room where employees may partake of fresh fruit and gather information about other helpful health related subjects.

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[redacted]mative resources to support and educate parents and families on practicing healthy living.

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