UnitedHealthcare Community Plan of Maryland

2021–2022 outreach programs

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United Healthcare Community Plan

I. Overview of UnitedHealthcare Community Plan

A. Mission

UnitedHealthcare is a business unit of UnitedHealth Group. UnitedHealthcare is 1 of 9 health plans participating in the HealthChoice Program. We are recognized by the Maryland Department of Health (MDH) as a managed care organization (MCO) providing health care services to Medicaid members in Maryland.

B. Objective

The objective of the outreach program is to generate practical solutions to this culturally and linguistically diverse population with complex medical, behavioral and social conditions. Our goal is to improve the health status of our members by addressing care opportunities for approximately 166,198 members. The outreach program is a member- and provider-centric model designed to use several data sources to identify members in need of medical services. Once identified, several approaches are used to assist with scheduling medical appointments including telephonic outreach (live and interactive voice recording). Other approaches include providing health information via the member newsletter and member website, sending reminder letters and using a contracted vendor to promote and support closure in gaps of care. The outreach staff educates members about the importance of maintaining good health by keeping scheduled appointment(s) for preventive care and consistent management of their chronic condition(s), as well as identifies and address barriers to care.

C. Member and provider outreach programs

New enrollee outreach

Outreach begins with a welcome call to all new enrollees informing them of the necessity of scheduling and completing an initial health appointment with their primary care provider (PCP). Procedures are in place to determine if appointments are scheduled and completed. UnitedHealthcare works with members, their PCPs and local health departments to schedule and complete the necessary appointment(s). Monthly and quarterly productivity report analyses are used to determine the number of members receiving telephonic or written outreach, the number and type of follow-up attempts made and the number of appointments scheduled.

UnitedHealthcare network management partnership

UnitedHealthcare Community Plan works collaboratively with UnitedHealthcare Network Management. One goal of this collaboration is to promote adherence to State of Maryland quality performance criteria and provide support resources. The collaboration between the health plan and network providers is to help ensure adequate knowledge of their contractual and regulatory obligations to promote and support the well-being of UnitedHealthcare members and their patients**.**

D. Summary of overview

UnitedHealthcare selects preventive service, chronic condition indicators that reflect important aspects of care for UnitedHealthcare members, and indicators that are relevant to the enrolled population and reflective of high-volume services that span a variety of delivery settings.

The selected measures are based on population and condition. Using multiple data sources including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS®) or state-provided data, members are identified for outreach. Claims and encounter data are monitored to identify members in need of services and to provide feedback to providers. The overall plan performance is monitored and evaluated on a continuous basis. Interventions are implemented as indicated for continuous quality improvement.

Communication with internal departments, including operations, case management, special needs, member services, utilization management and provider relations is ongoing to promote the continuity of care and work collaboratively on individual or population-based cases, when indicated.

Quality measure information and member-specific information is given to providers by the senior quality registered nurses (RNs) on a routine basis to provide up-to-date screening guidelines and notification of members among their panel who are due for screening. On-site visits to provider offices are also conducted for focused education and/or medical record review.

UnitedHealthcare staff develops partnerships with community and state agencies for community-wide health promotion. Through these partnerships, multiple resources are linked to enhance member and provider educational efforts. These resources may also be used to coordinate services and/or to identify additional means of contact for hard-to-reach members.

UnitedHealthcare emphasizes and encourages preventive health education and management of chronic conditions regularly, which includes completing an annual physical, age-appropriate immunizations and routine screenings. UnitedHealthcare staff work with community organizations, such as the Healthy Kids Program, and local health departments to help ensure there are no access barriers to care.

The current multifaceted UnitedHealthcare outreach efforts and tracking databases, as well as continued evaluation of strategies, will continue in 2022. The objective is to exceed performance expectations of our members and partners by offering important information about health plan activities, benefits and community events while consistently identifying strategies to improve member, provider and community partnerships.

II. Membership profile

Note: Data is from January 2021–October 2021.

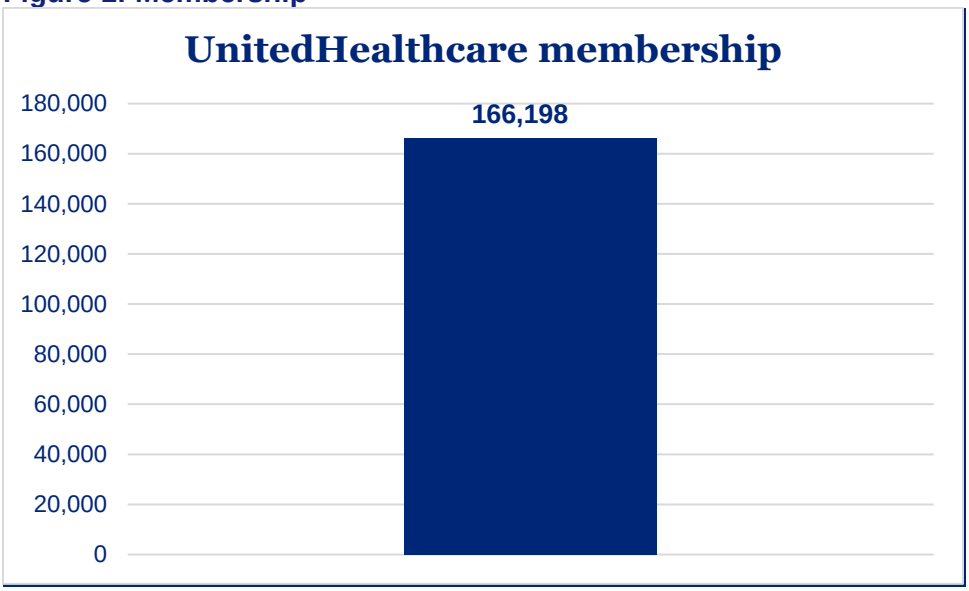
A. Population assessment

UnitedHealthcare members are comprised of the following groups: (1) families receiving Temporary Assistance for Needy Families (TANF), and (2) individuals receiving the Supplemental Security Income (SSI) benefit.

UnitedHealthcare provides outreach and care management to the following HealthChoice populations:

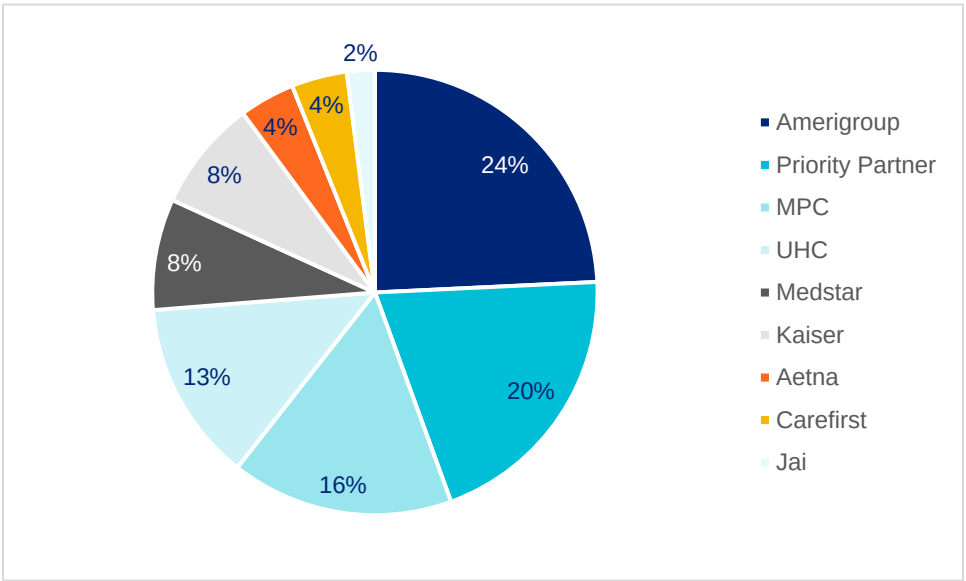
Special Needs Population	CY2019	CY2020	CY2021
Children with special health care needs	2,908	2,397	2,569
Individuals with a physical disability	2,590	2,264	2,625
Individuals with a development disability	4,337	4,151	4,510
Pregnant and postpartum women	3,891	3,860	3,717
Individuals who are homeless*	465	2,161*	2,397
Individuals with HIV/AIDS	522	763	1,090
Children under state supervision	2,627	2,462	2,432

Figure 1: Membership



Data source: January 2021–October 2021

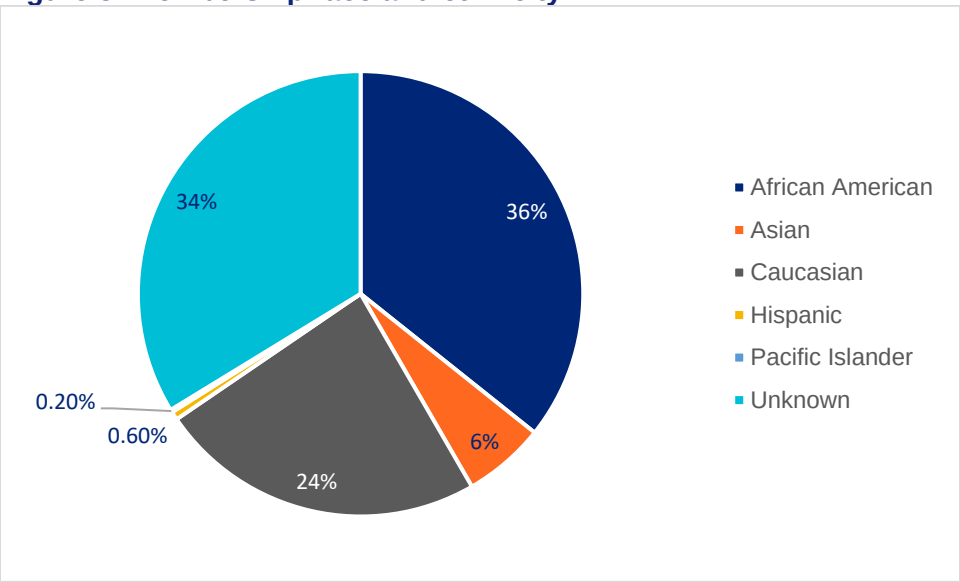
Figure 2: Medicaid Managed Care market share



Data source: October 2021

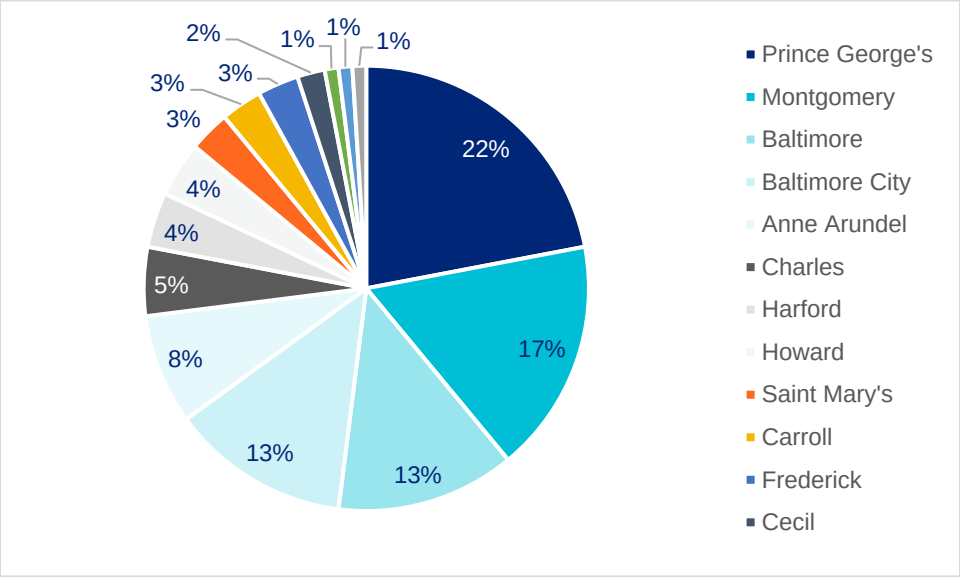
United Healthcare Community Plan

Figure 3: Membership race and ethnicity



Data source: January 2021–October 2021

Figure 4: Membership by county



Data source: January 2021–October 2021

B. Common health diagnoses

The following is an analysis of our most common inpatient, outpatient and emergency department utilization by diagnosis:

Top 10 inpatient diagnoses	Top 10 outpatient diagnoses
1. Single Liveborn Infant Deliver; Vaginally	1. Contact With Exposure Other Viral
2. Single Liveborn Infant Deliver, Cesarean	2. Contact With and (Suspected) Exposure to COVID-19
3. Sepsis Unspecified Organism	3. Encounter OBS Suspect Exposure
4. 2019-n CoV Acute Respiratory Disease	4. Obstructive Sleep Apnea
5. Maternal Care for Low Transverse	5. Encounter General Adult Med Exam
6. Post-Term Delivery	6. Encounter Screen Infection
7. Essential Hypertension	7. Encounter Rtn Child Health Exam
8. Abnormal Fetal Heart Rate	8. 2019-n CoV Acute Respiratory Disease
9. Type 1 Diabetes Mellitus w/Ket	9. Encounter GYN Exam General Rtn
10. Morbid Severe Obesity	10. Acute Pharyngitis Unspecified

Top 5 emergency department diagnoses
1. 2019-n CoV Acute Respiratory Disease
2. Other Chest Pain
3. Chest Pain Unspecified
4. Headache, Unspecified
5. Acute Upper Respiratory Infection

Based on the varying diagnoses for the 3 settings, different outreach and care management strategies are deployed. With the UnitedHealthcare cross-departmental, provider and community outreach approach, all 3 populations (children, women and adults with disabilities) are managed differently, but appropriately.

C. Quality performance

MDH measures the performance of UnitedHealthcare individually and all MCOs collectively through several initiatives, including audit and analysis of the Medicaid HEDIS® and Maryland State Value-Based Purchasing encounter reports. In addition to the clinical inpatient, outpatient and emergency department outreach opportunities identified, the following HEDIS® and value-based performance measures are tracked to help ensure initiatives are implemented to close care opportunities:

Quality performance measures	
Well-Child Services (infant, toddler, adolescent)	Controlling Blood Pressure
Immunizations	Breast Cancer Screening
Comprehensive Diabetes Care	Asthma Medication Ratio
Postpartum Care	Lead Screening
Supplemental Security Income (SSI) – Adult and Child	

MCO dimensions	Performance measures	UnitedHealthcare Rate HEDIS® Measurement Year 2019	UnitedHealthcare Rate HEDIS® Measurement Year 2020
Access to Care	% of adolescents, age 13, during the measurement year who had 1 dose of meningococcal vaccine and either 1 Tdap or Td vaccine by their 13th birthday	90.75%*	88.8%
Access to Care	% of SSI adults enrolled 320 or more days with at least 1 ambulatory service during the year	79.73%	76.80%
Access to Care	% of SSI children enrolled 320 or more days with at least 1 ambulatory service during the year	80.00%	70.00%
Access to Care	% of deliveries by a pregnant who had as postpartum visit on or between 7 and 84 days after delivery	73.84%	79.08%
Use of Services	% of children ages 12–21 receiving at least 1 well-child visit with PCP during the year	64.96%*	Due to trending break, this measure was not submitted
Use of Services	% of children ages 3–6 receiving at least 1 well-child visit with PCP during the year	83.70%*	Due to trending break, this measure was not submitted
Effectiveness of Care	% of children who turned 2 and who received combo 3 (all childhood immunizations) by their 2nd birthday	72.75%*	74.45%
Effectiveness of Care	% of children who turned 2 and who received lead testing by their 2nd birthday	74.35%	72.36%
Effectiveness of Care	% of women, ages 21–64, receiving at least 1 PAP test during the last 3 years	58.88%*	58.39%
Effectiveness of Care	The percentage of women, ages 50–74, who had a mammogram to screen for breast cancer	58.14%	55.50%
Effectiveness of Care	% of diabetics that received a dilated funduscopic eye exam during the year	51.34%	49.%

***Note:** For MY 2020, well-child visits were not submitted due to trending break.

D. Identified barriers to care

Based on member and provider reports, UnitedHealthcare develops targeted outreach to reduce barriers to care. A number of strategies are employed to contact members when appropriate based on age- or gender-specific guidelines. For example, a contracted vendor uses several modalities to contact members and arrange for their office visit including providing transportation or interpretive services.

All contact attempts are documented to help ensure all options have been exhausted. Members who cannot be contacted after several attempts are referred to their local health department for follow-up in accordance with Code of Maryland Regulations (COMAR).

Member barriers

- Fear of exposure to themselves or children to the COVID-19 virus during an office visit prohibited scheduling and keeping an appointment. Telemedicine may have not been an option due to either not having a computer/cell phone or internet connectivity although offered.
- Inaccurate member contact and demographic information makes it difficult to contact the member to provide health education or assist in scheduling appointments. The pandemic has added to the number of members whose living arrangements have been altered, which can include homelessness.
- Insufficient knowledge of their treatment plan and the relationship to improving or maintaining a healthy lifestyle. The member may also have poor understanding of the cause of the disease/condition and the medical treatment and management of the disease/condition. There may be inconsistent adherence to prescribed medications because the medication is perceived as not helping or causing other symptoms, which the member relates to the medication.
- Lack motivation/ability to visit primary care provider (PCP) for monitoring of their condition or difficulty making and attending appointments due to competing priorities. Additional reasons can include lifestyle changes, behavioral challenges, substance abuse, homelessness, as well as presence of multiple comorbidities requiring multiple PCP and specialist visits.
- Insufficient knowledge of covered benefits, for instance transportation coverage to the PCP's office, durable medical equipment or formulary versus non-formulary medications
- Supervision for multiple children may be a barrier to keeping an appointment. Attempting to schedule appointments for multiple children on the same day or approximate time can also be a challenge for the member.
- Coordination of care for children in foster care can pose a unique challenge

Health care professional barriers

- Provider practices closed some satellite facilities due to COVID-19 and/or reduced staff limiting the members access to their usual site of care or lack of availability to an appointment that is conducive to their work/school/childcare schedule
- Providers may be unaware of HEDIS® specifications and/or clinical practice guidelines
- Providers may not realize the number of missed appointments within their patient population
- Provider may be unaware of MCO resources to assist in member compliance, such as member outreach initiatives, available covered benefits and in-office outreach support

Regional barriers

- Rural regions present the greatest challenges to successful outreach efforts. There are fewer specialists in Western Maryland and the Eastern Shore than in suburban and urban locations.

In 2022, outreach efforts will continue to encourage and support scheduling and keeping appointment(s), address social or language/cultural barriers, provide health education to support and promote good health and well-being as well as reduce inpatient admissions and emergency department and urgent care visits.

III. Organizational resources and outreach activities

Outreach is based on 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 contributing to improving health care outcomes. This coordination of care provides an opportunity for an improvement in the quality-of-care continuum. The UnitedHealthcare outreach program offers services that address the entire continuum of clinical and preventive needs utilizing analytical data capabilities to assist in providing evidence on the improvement of care and services.

Multiple departments and vendors conducting member and provider outreach services, both independently and interdependently, are used to meet the goal of getting the member into care. Areas that perform outreach include, but are not limited to, the departments of Quality Management and Performance (QM, outreach and HEDIS® clinical quality nurses), Marketing, Healthy First Steps, Provider Network Management, Customer Service, Special Needs Coordination, Hospitality Assessment Reminder Calls, Disease Management and Fulfillment and Whole Person Care Case Management.

Quality Management and Performance department

Chief medical officer

The chief medical officer (CMO) is a Maryland-licensed physician with experience in quality management who is responsible for implementation of the Quality Management and Performance programs. The Clinical Quality Services team addresses utilization and quality performance, as necessary. In addition, pharmacy quality initiatives and provider prescribing practices are reviewed and discussed with providers when appropriate.

Director of quality management

The director of quality management is responsible for oversight and implementation of the Quality Management and Performance program, including monitoring the quality of care and service UnitedHealthcare provides and the evaluation of quality improvement initiatives involving member and provider outreach. In addition, the director of quality management:

- Maintains oversight of activities designed to increase performance on HEDIS®
- Prepares annual Quality Improvement (QI) program documents
- Submits quality regulatory reports
- Has day-to-day responsibility for implementation of quality improvement studies and patient safety initiatives

The director of quality management works with the compliance officer to help ensure quality programs are aligned with regulatory and accreditation standards. The director of quality management reports to the chief executive officer for the UnitedHealthcare Community Plan of Maryland to help ensure fiscal and administrative management decisions do not compromise the quality of care and service UnitedHealthcare provides to members.

Clinical quality manager (accreditation and regulation)

The quality manager supports quality improvement activities at the health plan level. The quality manager prepares quarterly regulatory reports, manages quality of care issues and interfaces with the CMO, Health Services, Medicaid Operations and Administrative Management to help ensure appropriate resolution of quality of care issues throughout the health plan. The results of these activities are reviewed at the Service Quality Improvement Sub-Committee (SQIS), Physician Advisory Committee (PAC) and Quality Management Committee (QMC) meetings. The quality manager reports to the director of quality management and communicates routinely with the CMO regarding quality-of-care issues.

Clinical quality manager (HEDIS®)

The HEDIS® quality manager is responsible for the direction and guidance on Clinical Quality Improvement and Management programs including accreditation. Conducts clinical quality audits and may be responsible for National Committee for Quality Assurance (NCQA) requirements. Responsibilities also include analysis and reporting of member care quality and the development of plans and programs to support continuous quality improvement using HEDIS® and other tools. The HEDIS® quality manager works co-jointly with the clinical quality manager, health educator and outreach supervisor to maximize work efforts. The quality manager presents HEDIS® updates to the appropriate quality management committees. This position reports to the director of quality management.

Clinical quality RN (formerly known as clinical practice consultant)

The senior quality RN is responsible for analysis and reviews of quality outcomes at the provider level. They provide education on quality programs and monitor and report on key measures to help ensure providers meet quality standards**.** The senior quality RN reports to the HEDIS® quality manager.

EPSDT quality nurse

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) quality nurse is responsible for helping ensure providers offering EPSDT services are fulfilling the MD Healthy Kids Program requirements outlined in the Healthy Kids Preventive Health Schedule via chart review. Additional responsibilities include, but are not limited to, offering education to support compliance of the preventive health schedule, identify and share ESPDT online resources as well as confer with the chief medical officer to develop additional interventions to support compliance. The EPSDT quality nurse reports to the clinical quality manager.

Outreach supervisor

The outreach supervisor oversees the clinical administrative coordinators, helping to ensure telephonic and mail outreach is maximized to reduce the total number of member care opportunities. The primary goal of the outreach staff is to help improve UnitedHealthcare member compliance with preventive and chronic health services. The outreach supervisor is also responsible for helping ensure that staff is well versed on HEDIS® measures, covered benefits and resources to reduce barriers to care. The outreach supervisor reports to the director of quality management.

Clinical administrative coordinators

Clinical administrative coordinators are dedicated to providing multifaceted outreach activities to bring the member into care to support chronic condition management and preventive services. Multiple data sources are used to determine if members need services. The clinical administrative coordinators report to the outreach supervisor.

Senior health coach

The senior health coach is responsible for the management of the health education program including, but not limited to, assessing health education and information needs for members and providers, developing appropriate learning materials and programs, assessing program effectiveness and providing summaries of the program participation. The senior health coach also writes topic-specific articles for the member and provider newsletters and participates in community or quality-sponsored events. The Physician Advisory Committee (PAC) reviews oversight of these activities. This position reports to the director of quality management.

Outreach activities

- Initial health appointment

  New enrollees are called by the Hospitality Assessment Reminder Call (HARC) team to determine if an initial health appointment has been made and kept. If not, a local outreach agent assists the member in obtaining an appointment with their assigned PCP. A review of claims data is used to determine if the member kept the appointment. Several attempts are made to help ensure the member keeps the appointment. If after several attempts, the member cannot be reached, a referral is sent to the local health department for assistance.

- Member appointment scheduling

  Members in need of care are identified using an encounter database. Those members are called to assist with scheduling an appointment. The member is asked if they would like assistance scheduling or rescheduling. If the member cannot be located, the member is referred to the local health department for follow-up. The local health department forwards their findings to UnitedHealthcare no later than 30 days of receipt of the UnitedHealthcare referral. All calls and dispositions are documented.

- Habitual no-show or missed appointment

  We'll assist practices in reaching out to UnitedHealthcare members who are either a no-show or who have missed 3 consecutive appointments. The practice can email or fax the missed appointment letter template to the outreach supervisor. Numerous attempts, using all available resources, are made to contact the member. The staff also determines if there are barriers to keeping the appointment. If barriers are identified, the staff will reschedule the appointment if requested or determine if there are resources available to remove the barrier.

  If we're unable to contact the member after 3 attempts, a local health department referral form is completed and forwarded for follow-up. The local health department forwards their findings to UnitedHealthcare no later than 30 days receiving the referral form. All calls and dispositions are documented for future analysis.

- Member rewards program

  UnitedHealthcare provides members in need of specific medical services the opportunity to receive gift card rewards if services are rendered by years end. Eligible members receive a mailer outlining the program including mailing back the attestation form as evidence the service was completed.

- Network management

  Network management supports outreach efforts by addressing barriers providers may experience, such as changes in UnitedHealthcare processes or procedures that may affect getting members into care.

- Clinical quality nurse

  Clinical quality nurses provide plan and state information/education by distributing the provider resource manual and the Patient Care Opportunity Reports (PCOR) during on-site office visits. This report identifies members needing a well visit, an immunization or a screening to close a care opportunity.

- Marketing

  Marketing conducts community events as well as coordinates outreach activities to encourage gap closure with health care professional practices.

- Disease management and fulfillment

  Health education material is sent to members that self-report specific chronic conditions. This provides information to the member, explains the importance of managing their chronic condition with their health care professional.

UnitedHealthcare Community Plan Case Management program

The UnitedHealthcare Case Management program is a population-based, disease management program that prioritizes transition case management and high-risk case management using member-centric interventions.

Transition case management

Transition case management (TCM) is a member-centric intervention designed to improve care for patients with care needs as they transition from the inpatient setting (acute inpatient, rehabilitation and skilled nursing facility) to home. These members are identified as being at highest risk for readmission within 30 days of discharge. The RN assigned to manage the inpatient utilization of UnitedHealthcare members complete a risk scoring tool (RST) that assesses the risk or readmission for approximately 20% of the members the RNs feel are at highest risk for readmission.

This assessment captures the member's hospitalization history, age, current length of stay, diagnosis, clinical condition, complexity of discharge needs, mental health status and the member's use of medications. UnitedHealthcare has also created a Readmission Predictive Model (RPM) that is run against 100% of the members with an inpatient admission. This proprietary predictive model focuses on age, sex, current and historical admitting diagnoses, history of admissions, most recent length of stay, outpatient specialist's visits, use of durable medical equipment, use of prescriptions, and whether or not the most recent readmission was, itself, a readmission.

Members with qualifying scores on the RST or the RPM are eligible for the TCM intervention. TCM is a short-term intervention that attempts to engage members in a discussion about their outpatient needs and barriers to accessing care and encourage compliance with timely ambulatory follow-up. The goal of TCM is to improve care transitions by providing members with the tools and support needed to promote knowledge and self-management skills to prepare them for and support their transition between settings. Members identified as appropriate for high-risk case management are referred for ongoing case management at the conclusion of the TCM intervention. The case management model consists of a multi-disciplinary team that includes health care physicians, psychiatrists, pharmacists, case management and maternity nurses, social workers and field-based community health workers who are able to complete face-to-face and telephonic case management. The case management model emphasizes the importance of a team approach by working with its members, providers and other health care team members to promote a seamless delivery of health care services.

TCM focuses on 4 conceptual areas:

1. Medication self-management: Member is knowledgeable about medication and has a medication management system
2. Primary care and specialist follow-up: Member schedules and completes follow-up visits with the PCP or specialist physician and is empowered to be an active participant in these interactions

3. Knowledge of red flags: Member is knowledgeable about indications that their condition is worsening and how to respond and educated regarding crisis resources in their community
4. Educate member on use of a personal health record: Member uses this knowledge to facilitate communication and help ensure continuity of care across providers and settings

High-risk case management

High-risk case management (HRCM) is a specialized, member-centric program for members identified as high risk for out-of-home placement. The HRCM group is generally identified in 3 ways:

1. The application of a predictive modeling tool
2. The application of a hotspotting tool
3. Daily clinical continuum rounds

Predictive modeling: All member claims data, demographics and the claims data from the State of Maryland's behavioral health vendor are run through a predictive model to identify those members who are persistent super utilizers (PSU). PSUs are members who either have been high utilizers of emergency department and/or inpatient services, are predicted to be high utilizers of the same services in the coming year or are predicted to be otherwise at high need of case management services in the coming year. Members who are identified and stratified as high risk are eligible for HRCM.

Hotspotting: The UnitedHealthcare hotspotting tool is a comprehensive scan of all available data to identify those members with recent, but not necessarily persistent, high utilization of emergency room and/or inpatient care. It can be used to identify those members in a high-risk category who have little to no community-based utilization, those with specific or significant social determinants of health and/or those who live in certain markets (towns, cities, ZIP codes or counties).

Daily clinical continuum rounds: Every morning, the chief medical officer (CMO) facilitates a meeting between the utilization management teams for inpatient, skilled nursing facilities and durable medical equipment, a pharmacist and the clinical managers of the Whole Person Care (WPC) staff. The histories and current presentations of members who appear to need the most community-based support is discussed. The CMO makes referrals to the WPC team of any members at high risk who may benefit from short- or long-term support in the community.

The goals of the WPC program are to assess for barriers to compliance, address any unmet needs, and provide education and support to improve member self-care management skills. Members appropriate for HRCM are assigned a case manager who is responsible for member engagement, assessment and reassessment. Case managers monitor a member's progress, collaborate with the member and their caregiver or PCP and community resources.

At a minimum, case management staff is available through a toll-free number from 8 a.m. to 5 p.m., Monday through Friday. All callers have the option to speak with an organizational representative at any time during business hours. Coverage for after-hours includes the use of NurseLine services, which provide call escalation, triage and medical advice 24 hours per day, 7 days per week. The member service line is available 24 hours per day, 7 days per week.

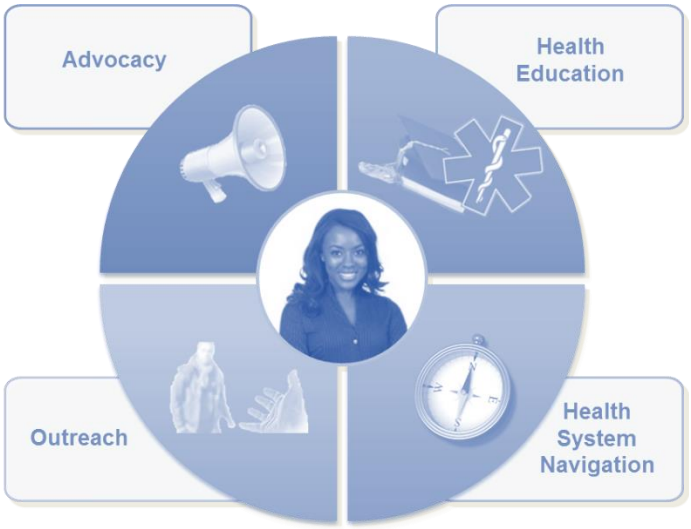
The case management telephone line is accessible to all Case Management program members and vendors, including providers, agencies, members, parents and caregivers. Contact information for the

case management line is included in all Case Management program materials, including handbooks, newsletters, brochures and the website, and is advertised in Spanish.

In our effort to make case management services accessible and user-friendly, we employ community health workers (CHW) with diverse foreign language capabilities, including Spanish. This effort is a part of our strategy to employ individuals whose language skills and cultural backgrounds mirror that of the enrolled population. To the extent possible, we hire nurses that can accommodate these prevalent languages and communicate with our members in their preferred language.

To supplement the staff's capabilities, a language line vendor and call center translation services are contracted. To address the needs of our hearing-impaired members, UnitedHealthcare relies on the capabilities of the National Relay System. In accordance with program performance standards and expectations, the UnitedHealthcare Case Management program services routine after-hours calls through a voice mailbox. A member of our case management staff responds to all messages left in this mailbox the next business day.

CHWs provide field-based interventions to locate and engage members and connect them to the PCP, which includes coordinating appointments as necessary. The CHWs refer member to RNs or behavioral health advocates for complex needs to address/remove barriers to care and access community resources and ultimately improve their ability to access care.



Whole Person Care

The Whole Person Care (WPC) case management model created as an interdisciplinary team of community health works, nurses, social workers, pharmacists and medical doctors (including both medical and psychiatric physicians). It incorporates enhanced screening tools to capture a large range of behavioral health issues to help ensure a holistic approach to member needs, including medical, behavioral and social/environmental needs. The primary goal is to help ensure the member receives the right care from the right providers, in the right place and at the right time. At the member level, this model ultimately leads to the development of person-centered care, which leverages interdisciplinary teams and combines the resources of UnitedHealth Group with medical homes and other integrated care organizations to reduce costs and improve outcomes. The WPC model seeks to empower members, providers and our community partners to improve care coordination and improve outcomes for individuals with the most complex conditions. This is performed by providing market-designated, field-based care management with the integration of medical, behavioral, social and environmental care.

WPC high-risk behavioral medical case management

Intensive case management identifies members, assesses treatment options and opportunities to coordinate care, design treatment programs to improve quality and efficacy of care, control cost and help ensure optimal outcomes. Members are outreached and engaged by the appropriate staff to help ensure the member's needs are met as well as the goals of the program.

Program goals are:

- Improve access to services – physical, behavioral, social and environmental
- Improve coordination of care through the assignment of dedicated staff to facilitate access to care and community resources to meet unique needs
- Improve systems of care and engage with the community and provider networks to help ensure access to affordable care and the appropriate utilization of services
- Improve health outcomes demonstrated by improved access to preventive care and compliance with evidence-based guidelines
- Empower the individual member to become successful in managing their chronic disease or condition and care transition

Healthy First Steps™ population identification

Data sources for the identification of members who are pregnant may include, but are not limited to:

- Member eligibility files (State 834 file indicators)
- Claims data, including:
  - Obstetric laboratory claims
  - Pharmacy data
  - Inpatient admission data
  - Emergency department data
  - Outpatient medical and behavioral health data
  - Claims data using specifications from the Health Plan Employer Data Information Set (HEDIS®) including current procedural technology and diagnosis codes (excluding intrauterine death and abortions)
- Non-delivery maternal inpatient admissions data

- Provider Referrals, Notifications of Pregnancy and Obstetrical Risk Assessment Forms (OBRAF)
- Member self-identification or caregiver referrals
- Internal staff referrals, including from:
  - Case managers
  - NurseLine staff
  - Hospitality, Assessment & Reminder Center (HARC) staff conducting welcome calls and/or health risk assessment calls
  - Advocate4Me member services staff who receive inbound customer services calls and coordinate services to close gaps in care
  - Staff from other health management, wellness or coaching programs
- Health Risk Assessment data
- Data from electronic medical record (EMR) feeds when available

Inpatient census reports identify members with antepartum or postpartum complications. Healthy First Steps inpatient care managers review and authorize care while the member remains in the facility. Referral for care management occurs when member is an inpatient.

Pregnant members accessing care through hospital emergency departments are identified and reassessed by an OB care manager for additional risks. All identified pregnant members are eligible for Healthy First Steps and are included in program enrollment unless they specifically request to be excluded.

Healthy First Steps interventions

Healthy First Steps offers a variety of member outreach initiatives and interventions. General education and outreach is offered to all pregnant women, with specialized support provided to those who have been stratified to a high-risk pregnancy program.

Member Services team outreach

All members identified as pregnant are contacted by the dedicated UnitedHealthcare maternity Member Services team. They will provide general information about the Healthy First Steps program, conduct an initial maternity risk assessment and enroll members in a healthy or high-risk pregnancy program based on the results of the assessment. They will assist the member in scheduling their first prenatal appointment if this has not yet occurred. Additionally, the Member Services team will identify any barriers the member might have, such as transportation or child care needs, and connect the member to appropriate national or community-based resources. The Member Service agents will refer all high-risk members to the maternal child health program coordinator for monitoring and/or clinical intervention.

Community Health Worker Outreach program

In addition to outreach from the Member Services team, members may receive in-person or telephonic outreach from local community health workers (CHWs). The health plan's maternal child health program coordinator will refer high-risk members who could not be contacted or who are no longer engaged with the program to CHWs. Similar to above, the CHW will refer all high-risk members to the maternal child health program coordinator for monitoring and/or clinical intervention.

Maternal child health program coordinator/maternity case manager outreach

The health plan's maternal child health program coordinator and/or maternity case manager(s) may make proactive outreach to members that are initially stratified as high risk. This outreach may be additive to that conducted by the Member Services team or CHWs.

Ongoing health education for all members

All pregnant women, regardless of risk or engagement with a provider, will receive:

- A welcome letter with information that tells her about the Healthy First Steps program, how she became eligible and how the member can opt out if she chooses not to participate. Also included are educational materials that explain what she can expect from her pregnancy. Members are encouraged to call the health plan with questions or concerns regarding their pregnancy and ways to connect to programs such as our digital education and Health First Steps Rewards program (formerly named Baby Blocks).
- Throughout her pregnancy, each member receives education through a variety of channels, including mail, email, automated or live calls, and/or materials supplied by obstetric practitioners. Consistent with the Health First Step program's commitment to addressing health disparities, member education and materials will also address psychosocial issues such as cultural beliefs concerning pregnancy and delivery, perceived barriers to meeting treatment requirements, and access, transportation and financial barriers to obtaining treatment.

Maternal child health program coordinator/maternity case manager monitoring

Members who are enrolled in the Healthy First Steps program will be monitored by the health plan's maternal child health program coordinator and/or maternity case manager(s). Should the maternal child health program coordinator identify a member with additional medical, behavioral, social or care management needs or who is not consistently accessing prenatal care, they will outreach to the member. They will work closely with the member to establish or reestablish contact with their OB practitioner, any specialty care and social service needs. The maternal child health program coordinator shall monitor high-risk members regularly through reporting, automated systems alerts and other standard monitoring methods to help ensure program requirements are being met.

Maternal opioid use disorder/substance use disorder

Pregnant members with opioid use disorder (OUD)/substance use disorder (SUD) and their infants are a particularly vulnerable population in the current opioid epidemic. Infants whose mothers used opioids during pregnancy can experience a postnatal withdrawal called neonatal abstinence syndrome (NAS). To help these members, we offer assistance to connect pregnant women with medication-assisted treatment (MAT) consisting of pharmacotherapy with methadone or buprenorphine, as well as evidence-based behavioral interventions through case management and the Substance Use Disorder Helpline. Our Substance Use Disorder Helpline is a no-cost service available 24/7 for members that need substance use support. Additionally, we connect members to services as needed, such as trauma-informed care, housing, food resources, individual and peer counseling, transportation services and childcare resources. These resources and support extend into the postpartum period to focus on social determinants of help and barriers to successful MAT. Any infant with the diagnosis of NAS is offered yearlong dyad care management to help ensure successful treatment and support throughout the essential first year of life.

17P/Makena Progesterone program

The 17P/Makena Progesterone program is designed to address women who have previously delivered a premature infant. A referral is made to the Optum OB Homecare program or other contracted providers as appropriate. With an appropriate authorization from her practitioner, the member will receive case management, ongoing education and coordination of delivery of the 17P/Makena treatments, either through the practitioner's office or in the member's home, if appropriate and available.

Providers

- Enhance relationships and support to network providers and practitioners
  - Improve provider and practitioner satisfaction by offering a comprehensive suite of tools, education, and support in the delivery of care to pregnant women and their babies
  - Adopt and disseminate nationally accepted pregnancy and early childhood clinical practice guidelines
  - Establish further collaborative relationships with network providers and practitioners with a focus on improving prenatal and postpartum care, risk assessment, and promotion of healthy behaviors as part of shared savings arrangements and quality incentives
  - Collaborate with obstetric providers on data exchange regarding patient adherence to treatment plans, condition monitoring and management of comorbid conditions
  - Monitor performance of practitioners and providers against evidence-based guidelines

Annual updates are given to providers regarding clinical practice guidelines and program changes using the following modalities:

- Provider website
- Provider care manual and newsletters located on the provider website specify details on program referral and access, as well as other resources and tools
- Each provider who has a member receiving care management services receives a letter of notification with staff contact information and an invitation to participate in the Healthy First Steps plan of care. The care manager may contact the PCP or sub-specialist to design interventions for the member. Care managers may contact the obstetrical provider to report concerns, barriers to care, or for recommendations and assistance with completing interventions. Healthy First Steps medical directors with obstetrical and related board specialties are available for peer-to-peer discussions. These contacts are intended to facilitate effective communication and partnerships between Health First Steps staff and obstetrical providers while coordinating care for optimal maternal and infant outcomes.
- Consultant notification is completed keeping with American College of Obstetricians and Gynecologists (ACOG) Guidelines for Perinatal Care. Providers may receive notification if their patient has an identified risk factor and a consultation with an obstetrician or maternal fetal medicine specialist is recommended.

Utilization Management department

The Utilization Management (UM) department functions as a multidisciplinary team that places the member in the center of all activities. All UM decisions are objective and based on appropriateness of care and service as well as the existence of coverage. UM decision makers are not rewarded for issuing denials of coverage of care nor do they receive financial incentives that encourage decisions that result in underutilization. The primary goal of the UnitedHealthcare Utilization Management program is to help ensure that all members seeking services receive timely and appropriate care. Services are provided through the use of contracted inpatient facilities, residential facilities, partial hospital programs, intensive outpatient programs and a multidisciplinary network of outpatient providers.

United Behavioral Health

The State of Maryland designated Optum Maryland as the provider of specialty behavioral and substance abuse services as an Administrative Services Organization (ASO), effective 2020. UnitedHealthcare does provide behavioral health case management services to its member as an integrated service under the Whole Person Care Model. Our behavioral health advocate leads efforts of integrating behavioral and physical care management under the guidance of a multidisciplinary team approach that includes the chief medical officer and Optum psychiatry medical director. The UnitedHealthcare Community and State plan additionally collaborates with the United Behavioral Health ASO to coordinate care through formal rounds and direct collaboration leveraging the behavioral health advocate.

Customer Service department

UnitedHealthcare customer service representatives educate members when they call in with questions about benefits, procedures and services. The same services are provided for the hearing impaired or foreign language-speaking members using AT&T's Language Line and TTY (this program offers translation services to those with hearing impairments).

Additionally, if a member is put on "hold" while waiting for a customer service representative, they are able to hear educational promotions on UnitedHealthcare phone lines. These pre-recorded promotions educate members on several topics including, but not limited to, heart disease prevention, asthma, outdoor safety, sun protection, immunizations, breast awareness, nutrition, flu prevention, diabetes management and behavioral health education.

IV. Tracking and monitoring outreach activities

Database and software applications

UnitedHealthcare uses several data systems to manage and perform outreach services to members. These data systems include Facets, Claimsphere, Hotspotting tool, Community Care, ICUE, Microsoft's suite of applications (Word, Excel and PowerPoint) and an outreach database. A health risk assessment reporting program is utilized to tailor the enrollment data received from MDH to conduct outreach within required timelines.

The desktop working system employed by the UnitedHealthcare quality, outreach and HEDIS® staff is a Windows-based system that allows easy access to all functional areas including claims, customer service, health services, provider, enrollment and eligibility.

Case management utilizes Community Care, Impact Pro and CRISP. In addition to serving as a tool for documentation for authorization of services, it contains screens for documentation of clinical notes, including outreach activities. Cases are accessed by a care identification number and can be viewed and updated by any staff member with access privileges.

The outreach staff utilizes a customized Microsoft Access database. The database uses member population data, based on HEDIS® specifications, from Claimsphere software for specific HEDIS® measures. The application identifies members who are missing specific clinical services, such as childhood immunizations or well visits. The database system is supplemented through the SMART data warehouse for claims research, member demographics and provider to enhance appointment scheduling.

The Hotspotting Data tool enables the identification of cohorts of members for specific interventions. The core member dashboard provides a host of filters to segment membership into very specific levels by demographics, utilization and cost, diagnosis and risk factors as well as engagement in various care management initiatives.

V. Community partnerships

UnitedHealthcare continues to develop and maintain various partnerships within the community it serves. These relationships are nurtured in an effort to reach out to current and potential members with the goal of providing quality health care including information and resources to individuals in the communities we serve.

In 2021, UnitedHealthcare remained focused on strengthening our relationships in the community with our partners and members, and addressing the COVID-19 related activities such as vaccination and testing efforts. Current UnitedHealthcare marketing initiatives and programs encourage our members and the community to become more engaged with their health and the health of their families. Each program included components to help ensure members were educated on their benefits, able to navigate the health plan and access care. UnitedHealthcare continues to bridge the gap between the member and the access to social needs through community partnerships.

The following 2021 community activities included:

- Baby shower
- Baby shower – virtual
- Back-to-school
- Back-to-school – virtual
- UnitedHealthcare Consumer Advisory Board (CAB) meeting – virtual
- UnitedHealthcare Community Advisory Committee (CAC) meeting – virtual
- Community event
- Community event – virtual
- Community event – donation only
- COVID-19 testing event
- COVID-19 vaccination event
- Family Fit
- Family Fit – virtual
- Farmers' market
- Food distribution
- Food distribution – donation only
- National Federally Qualified Health Center week
- Kid Fit
- Kid Fit teen
- Local Health Improvement Committee (LHIC) meeting
- Member appreciation event
- Member appreciation event – Spanish
- Provider

- StayFit adult
- StayFit adult – virtual
- TeenFit – virtual
- United For Work – virtual
- Wellness forum
- Wellness forum – virtual

A series of health education sessions focus on good nutrition, healthy eating, women, prenatal and heart health, asthma, substance abuse, cold, flu and smoking cessation. The sessions provided an opportunity to educate members and the community on helpful resources to maintain a healthy lifestyle. Health plan overview was also provided at the community events. Our participation with community partners will continue in 2022.

2021 event locations:

- Access Art
- Adelphi Langley Park Family Support Center
- Asian American Center of Frederick
- Back River Head Start
- Baltimore Connect
- Baltimore County Public Schools
- Baltimore County YMCA Head Start
- Baltimore Healthy Start
- Baltimore Medical Systems Admin Building
- Baltimore Medical Systems East Baltimore
- Boys and Girls Club
- Brooklyn Park Library
- Campfield Head Start
- Community Assistance Network – Essex
- Community Assistance Network – Hillendale
- Carrollton Elementary School
- CCI Health and Wellness
- Charles Carroll Middle School
- City of New Carrollton
- Community Action Council of Howard County
- Community Outreach & Development CDC
- Crossroads Farmers Market
- Doleman Black Heritage Museum
- Douglass Homes HABC
- Eastern Family Resource Center
- Edgemere Church of God
- Emergency Services for Adults and Families

- Family Healthcare of Hagerstown
- Fishes and Loaves
- Fleming Head Start
- Fontana Village Community Center
- Gloria’s Gifts Inc.
- Greater Baden Medical Services Inc
- Greater Baden Medical Services WIC
- Greater Lighthouse Church
- Green & Healthy Homes Initiative
- Hammond Middle School
- Hazelwood Elementary Middle
- Health Care for the Homeless
- Health Partners Inc
- Heritage Community Church
- Highland Village Head Start
- Holy Cross Hospital
- Howard County Fire and Rescue Services
- Howard County Health Department
- Judy Center at Campfield
- Judy Center at Hawthorne
- Judy Center at Georgetown East Elementary
- Judy Hoyer Center at Carmody Hills Elementary
- Kenwood Head Start
- Langley Park Civic Association
- Langley Park McCormick Elementary
- Laurel Elementary
- Laurel Woods Elementary
- LindaBen Foundation
- Lourie Center Early Head Start
- Manna
- Maryland Legislative Caucus
- Mary’s Center PG & Mo County
- Megan’s Place
- Meritus Health
- Merritt Park Head Start
- Morrell Park Elementary /Middle
- Mt Pleasant Church and Ministries
- Muslim Community Center Medical Clinic
- North Chester Head Start
- Northwest Faith Based Community Partners

- Oaklands Elementary School
- Prince George's County Health Department
- Progress Place
- Randallstown Head Start
- Riverview Head Start
- Robert R. Gray Elementary
- Robert W. Johnson Community Center
- Rogers Heights Elementary
- Shepherd's Table
- Sowing Empowerment & Economic Develop
- Springboard Windsor Valley
- St. Vincent de Paul Head Start
- The Beacon House
- Thomas S. Stone Elementary School
- Total Health Care
- Towson Head Start
- Village at Lakeview
- William Bean Elementary
- Woodland Springs Housing

Consumer Advisory board

The UnitedHealthcare Community Plan Consumer Advisory Board (CAB) is a valued relationship with our members. The CAB is mandated by the State of Maryland to facilitate obtaining receipt information from members of the health plan. The meetings are hosted 6 times a year at the UnitedHealthcare office in Columbia and have 8 active members.

The board's format encourages open dialogue between the members and the health plan. Each meeting is designed to provide health education, community resources, address member concerns and share updates on the health plan. The CAB members are also asked to review and provide feedback on new member materials, health education program plan, advertising materials, benefit changes and community initiatives. The topics discussed in 2021 were:

- 2020 member experience survey results
- Heart health
- Nutrition during COVID-19
- What is quality improvement
- Meditation and mindfulness
- Population health management strategies
- Family tree services
- Addressing barriers to care
- Population health management: Lead in children
- Howard County Cancer program
- CAB survey results

- Assessing member understanding

Consumer Advisory Committee

In 2021, UnitedHealthcare continued to improve our health services through our Community Advisory Committee (CAC). The CAC is dedicated to local health departments, providers, community and faith-based organizations that serve the Medicaid population. UnitedHealthcare meets quarterly to discuss opportunities and address challenges that may plague specific counties. The goal is to improve services and learn specifically from those utilizing services. The CAB was hosted virtually in 2021.

VI. Working with local health departments

UnitedHealthcare collaborates with the local health department (LHD) in various ways. UnitedHealthcare attends LHD's monthly meetings where concerns, barriers and potential interventions are discussed. UnitedHealthcare works with the LHDs to find solutions to problems, determine better methods of access and care coordination, and identify opportunities for greater provider involvement. Evidence of this partnership is the coordination of efforts to address specific health disparities based on geographic location and level of disparity amongst races.

The LHD also assists in locating and/or contacting UnitedHealthcare members and encouraging them to get preventive or chronic care health services. If the LHD is successful in finding the member, the Outreach team updates the demographic information and proceeds with efforts to assist the member with obtaining an appointment. If the LHD is not successful in finding the member, the health plan will use other modalities in an attempt to locate the member. UnitedHealthcare maintains a detailed referral process to the ACCUs that includes the tracking and trending and monitoring of referrals sent and received. UnitedHealthcare will continue working in partnership with all LHDs on outreach efforts, local events and other activities to better serve members in calendar year 2022.

VII. Role of the provider

To help ensure UnitedHealthcare members have every opportunity to access needed health-related services, network providers participate in telephonic audits to make sure they are meeting MHD appointment scheduling standards as well as EPSDT requirements. It is the expectation of UnitedHealthcare network providers to perform member outreach for members assigned to their panel.

UnitedHealthcare procedures regarding provider outreach is provided during Joint Operations Committee (JOC) meetings and town hall meetings. Network providers are encouraged and expected to review the provider care manual that outlines their responsibilities as it relates to caring for the Medicaid population and interact with their provider advocate to obtain information on benefits, regulations, policies and procedures for referral/pre-authorizations, drug formulary, etc. Providers are encouraged to participate in town hall meetings, view provider training at **UHCprovider.com/training,** and visiting **UHCprovider.com** for information on a variety of topics.

Evaluation of the Outreach program

Outreach approaches are monitored, data analyzed and appropriate interventions deployed. The current approaches and partnerships help ensure members are:

- Reminded of their need for service(s)
- Educated about the importance of completing needed services
- Informed about their covered benefits including directing them to sites that provide information
- Assisted with addressing social barriers to care
- Assisted with addressing their cultural or linguistic needs

2021 local and national outreach activities

Activity	Volume
Telephonic outreach	15,374 local outreach calls 18,067 IVR calls
Live telephonic outreach by vendor	33,453 unique member calls
Appointments scheduled by outreach agent	247 appointments scheduled
Letters when unable to reach by phone	14,100 “Sorry We Missed You” letters mailed
EPSDT preventive letters	111,247 letters mailed
Member Incentives for Gap Closure (WCV)	56,035 mailed
Healthy First Steps Rewards program	45,212 program mailers to members 6,034 members registered for the program 6,366 pregnancies completed • 58% completed prenatal visit • 28.8% completed postpartum visit
Disease management brochures **(Asthma, heart failure, COPD, coronary artery disease and diabetes)**	4,832 disease-specific mailers (January–September 2021)

Note: Volumes are YTD (Sept. 30, 2021)

Note: The pandemic has been a barrier to scheduling appointments regardless of outreach activities.

The aforementioned outreach activities were instituted to promote, encourage, support and assist members into care to improve or sustain their health and well-being. Health information/education efforts, through community events and partnerships, were used to assist the member in becoming an active participant in their care through self-care management, when appropriate and possible.

Additionally, auxiliary services such as case/care management or special needs coordination were an important part of outreach to member with complex conditions.

In 2021, several outreach approaches were employed to encourage members to schedule and keep their appointment. The outreach agents performed live calls, which provided health information, explained the importance of keeping appointments, offered resolution to specific barriers to care issues expressed including, social, language or cultural barriers, and provided information on covered benefits. There were reminder IVR calls and letters sent, and community events and community partnership meetings were conducted. The outreach work plan is used to track outreach activities and presented to the appropriate quality committees.

2021 was challenging because members did not want to complete a visit for fear of exposure to the COVID-19 virus. Many of the activities were resumed, except for activities that required a face-to-face engagement with members.

During live calls, members were informed that telehealth visits were an option to an office visit. For members with complex care needs or those designated under SSI, the special needs coordinator made calls to identify needs that could be met by telehealth visits or informed of community resources as deemed appropriate.

In 2022, outreach activities will continue. Modifications may be implemented to address the State's COVID-19 status. The focus, even if modified, will remain to promote, encourage, support and assist members into care to improve or sustain their health and well-being. Health information/education efforts, through community events and partnerships, will be used to assist the member in becoming an active participant in their care through self-care management, when appropriate and possible. Additionally, auxiliary services such as case/care management or special needs coordination will be an important part of the member outreach.

United Healthcare Community Plan