UnitedHealthcare Community Plan of Maryland

2022 - 2023 outreach programs

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I. Overview of UnitedHealthcare Community Plan of Maryland

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 173,189 members. The outreach program is a member and health care professional 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 preventative care and consistent management of their chronic condition(s), as well as identifying and addressing barriers to care.

C. Member and health care professional 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 (LHDs) 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 of Maryland 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 health care professionals is to help ensure adequate knowledge of their contractual and regulatory obligations to promote and support the well-being of UnitedHealthcare members and thei 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 population and condition based. Using multiple data sources including, but not limited to, 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 health care professionals. 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 to work collaboratively on individual or population-based cases, when indicated.

Quality measure information and member-specific information is given to health care professionals 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 health care professionals' 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 health care professional 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.

UnitedHealthcare current multifaceted outreach efforts, tracking databases and continued evaluation of strategies will continue in 2023. 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, health care professional and community partnerships.

II. Membership profile

Note: Data is from January 2022–October 2022.

A. Population assessment

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

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

Special needs population	CY2020	CY2021	CY2022
Children with special health care needs	2,397	2,569	2,580
Individuals with a physical disability	2,264	2,625	3,230
Individuals with a development disability	4,151	4,510	4,921
Pregnant and postpartum women	3,860	3,717	3,876
Individuals who are homeless*	2,161*	2,397	1,978
Individuals with HIV/AIDS	763	1,090	1,023
Children under state supervision	2,462	2,432	2,302

Data Source: *The increase in the number of members identified as individuals who are homeless is related to the use of Z-codes (non-medical factors that may influence the health status) in conjunction with claims data.

Figure 1: Membership

Data source: January 2022–October 2022

Figure 2: Medicaid Managed Care market share

Data source: January 2022–October 2022

Figure 3: Membership race and ethnicity

Data source: January 2022–October 2022

Figure 4: Membership by county

Data source: January 2022–October 2023

B. Common health diagnoses

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

Top 10 inpatient diagnoses	Top 10 outpatient diagnoses
1. Single liveborn infant delivery; vaginally	1. Contact with and (suspected) exposure to COVID-19
2. Single liveborn infant delivery, cesarean	2. Contact with exposure other than COVID-19v
3. Sepsis unspecified organism	3. 2019-n CoV acute respiratory disease
4. Maternal care for low transverse	4. Encounter routine child health exam
5. Post-term pregnancy	5. Encounter general adult med exam
6. 2019-n CoV acute respiratory disease	6. Obstructive sleep apnea
7. Abnormal fetal heart rate	7. Acute pharyngitis unspecified
8. Type 1 diabetes mellitus w/ketones	8. Encounter for screening for COVID-19
9. Morbid severe obesity	9. Encounter GYN exam general routine
10. Acute respiratory failure w/hypoxia	10. Essential primary hypertension

Top 5 emergency department diagnoses
1. 2019-n CoV acute respiratory disease
2. Other chest pain
3. Acute upper respiratory infection
4. Chest pain (unspecified)
5. Headache (unspecified)

Based on the varying diagnoses for the 3 settings, different outreach and care management strategies are deployed. With the UnitedHealthcare cross-departmental, health care professional 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 gaps in care:

Quality performance measures
Well-child services (infant, toddler, adolescent)
Immunizations
Comprehensive diabetes care
Postpartum care
Supplemental Security Income (SSI) – adult and child
Controlling blood pressure
Breast cancer screening
Asthma medication ratio
Lead screening

MCO dimensions	Performance measures	UnitedHealthcare rate HEDIS measurement year 2020	UnitedHealthcare rate HEDIS measurement year 2021
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	88.8%*	87.83%
Access to care	% of SSI adults enrolled 320 or more days with at least 1 ambulatory service during the year	76.80%	78.6%
Access to care	% of SSI children enrolled 320 or more days with at least 1 ambulatory service during the year	70.00%	78.5%
Access to care	% of deliveries by a pregnant who had a postpartum visit on or between 7 and 84 days after delivery	79.08%	77.37%
Use of services	% of children ages 12–21 receiving at least 1 well-child visit with PCP during the year	Due to trending break, this measure was not submitted	12-17 yrs. 62.74% 18-21 yrs. 41.75%
Use of services	% of children ages 3–6 receiving at least 1 well-child visit with PCP during the year	Due to trending break, this measure was not submitted	3-11 yrs. 68.21%
Effectiveness of care	% of children who turned 2 and who received combo 3 (all childhood immunizations) by their 2nd birthday	74.45%*	39.90%
Effectiveness of care	% of children who turned 2 and who received lead testing by their 2nd birthday	72.36%	71.07%
Effectiveness of care	% of women, ages 21–64, receiving at least 1 PAP test during the last 3 years	58.39%*	59.12%
Effectiveness of care	The percentage of women, ages 50–74, who had a mammogram to screen for breast cancer	55.50%	57.25%
Effectiveness of care	% of diabetics that received a dilated funduscopic eye exam during the year	49%	45.01%

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

D. Identified barriers to care

Based on member and health care professional 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.
- Lacks motivation or ability to visit 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, or homelessness, as well as the 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 (DME) 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

- Health care professionals' practices closed some satellite facilities due to COVID-19 and/or reduced staff, limiting the members' access to their usual site of care or causing a lack of availability to an appointment that is conducive to their work/school/childcare schedule
- Health care professionals may be unaware of HEDIS specifications and/or clinical practice guidelines
- Health care professionals may not realize the number of missed appointments within their patien population
- Health care professionals 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 2023, 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/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 result 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 health care professional 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 (QM) and Performance (QM, outreach and HEDIS® clinical quality nurses), Marketing, Healthy First Steps™ (HFS), 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 health care professional prescribing practices are reviewed and discussed with health care professionals 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 (QI) initiatives involving member and health care professional outreach. In addition, the director of Quality Management:

- Maintains oversight of activities designed to increase performance on HEDIS
- Prepares annual 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 QI 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.

Quality field operations manager, (formerly known as clinical quality manager)

The quality field operations manager is responsible for the direction and guidance on Clinical Quality Improvement and Management programs, including accreditation. The quality field operations manager conducts clinical quality audits and may be responsible for National Committee for Quality Assurance (NCQATM) 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 quality field operations manager works co-jointly with the clinical quality manager, health educator and clinical operations manager to maximize work efforts. The quality field operations 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 health care professional level, provides education on quality programs and monitors plus reports on key measures to help ensure health care professionals meet quality standards. The quality RN reports to the quality field operations manager.

Early and Periodic Screening, Diagnostic and Treatment quality nurse

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

Clinical operations manager (formerly known as outreach supervisor)

The clinical operations manager oversees the clinical administrative coordinators, helping to ensure telephonic and mail outreach is maximized to reduce the total number of gaps in care by members. The primary goal of the outreach staff is to improve UnitedHealthcare member compliance with preventive and chronic health services. The clinical operations manager is also responsible for helping ensure that staff is well versed on HEDIS measures, covered benefits and resources to reduce barriers to care. The clinical operations manager 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 clinical operations manager.

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 health care professionals, 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 health care professional newsletter 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.

Tracking and monitoring outreach activities include the following:

- **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. After several attempts and the member cannot be reached, a referral is sent to the respective local health department for assistance in locating the member. Feedback from the local health department is expected within 30 days of receiving the referral. If no response is received within 30 days, the respective local health department is contacted to determine the reason for not obtaining a response. All communication with the local health department, including their responses, is documented in the database.
- **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. If no response is received within 30 days, the respective local health department is contacted to determine the reason for not obtaining a response. All communication with the local health department, including their responses, is documented in the database.
- **Habitual no-show or missed appointment**
  Health care professional practices are offered assistance with outreach 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 clinical operations manager. 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 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 of receipt of a UnitedHealthcare referral. If no response is received within the 30 days, the respective local health department is contacted to determine the reason for not obtaining a response. All communication with the local health department, including their responses, is documented in the database.

- **Member rewards program**
  UnitedHealthcare provides members in need of specific medical services the opportunity to receive gift card rewards if services are rendered by year 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 health care professionals 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 or state information/education by distributing the provider resource manual and the patient care opportunity reports (PCOR) during onsite office visits. This report identifies members needing a well visit, an immunization or a screening to close the gap in care.
- **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 and explains the importance of managing their chronic condition with their health care professional.

UnitedHealthcare Community Plan care model

The UnitedHealthcare Community Plan of Maryland and the State of Maryland care model serve to optimize the health and well-being of members with emerging-risk and high-risk conditions that cause adverse health outcomes. To accomplish this, UnitedHealthcare employs an integrated complex clinical management model that is member-centric and facilitates collaboration between our members and their health care teams. These programs focus on improving member self-management skills, active decision-making and participation in social determinants of health interventions personalized to their risk profile and conditions. We target members who are most at risk for adverse health outcomes and most affected using care management to promote active oversight of their condition(s).

The care model program includes members enrolled in both Medicaid and Dual Special Needs Health Plans. It promotes engagement and care that embraces the use of the members' interdisciplinary care teams that are fostering education, member self-management and access to community resources. The care model focuses on members who have complex conditions, at-risk individuals with acute and/or chronic health care needs and members with emerging, moderate risk who have chronic illnesses or conditions and would benefit from proactive management of anticipated clinical needs. The care team in totality provides targeted evidence-based interventions that are individualized to the members' conditions. Members get the benefit of having a single point of contact living within their community to help manage their care and coordinate services across internal and external interdisciplinary teams, focusing on the members' preferred outreach modality and frequency. The model can be adapted and tailored to the needs of Medicaid subpopulations and other special needs populations identified by state-specific contractual requirements.

Data sources

Community and state utilize multiple data sources to identify members for care management programs. Data is analyzed monthly to identify members. Data sources are also used to identify and stratify members into appropriate care model programs which can include, but are not limited to the following:

- Medical and behavioral claims or encounter data
- Pharmacy claims/pharmacy data
- Laboratory results/data
- Health appraisal results/risk appraisals/scoring tool
- Electronic health records or data supplied by practitioner
- Health services with the organization/medical management programs, including data collected through the Utilization Management (UM) process
- Data supplied by member, caregiver, discharge planner, client or purchaser, or practitioner referral
- Advanced data sources

Goals and interventions

The goal of complex case management is to help enrollees regain optimum health or improved functional capability in the right setting and in a cost-effective manner. It involves a comprehensive assessment of the following:

- The enrollee's health status
- The determination of available benefits and resources
- The development and implementation of a patient-centered plan of care to include performance goals, monitoring and follow up

The clinical care model addresses the whole person, regardless of diagnosis. Gaps in care are identified and discussed with the member when the mutually agreed plan of care is developed. Complex case managers facilitate initial outreach and assessment according to NCQA™ guidelines and in collaboration with the member or caregiver. Interventions include, but are not limited to the following:

- A member-centric case management plan including prioritized goals that consider the member's and caregiver's goals, preferences and desired level of involvement in the case management plan
- Identification of interventions with timelines to meet the goals
- Identification of barriers to meeting goals or complying with the plan
- Development of a schedule for follow up based on members' acuity level and/or identified, agreed-upon needs
- Assessing progress against case management plan and adjusting the care plan and its goals, interventions and opportunities based on members'/caregivers' evolving needs and priorities
- Locating available community resources, including vendors/DME health care professionals, to assist with member-identified health care related issues

UnitedHealthcare will make repeated attempts to engage identified high-risk enrollees in our complex case management program. We offer an opt-out complex case management program (as applicable based on program requirements) where eligible enrollees may have the option to participate or decline participation. If the member decides to opt out, UnitedHealthcare informs the member of the benefits of the program so the member can make a fully informed decision. UnitedHealthcare care teams also teach members about the benefits associated with a care management program for future needs and considerations.

Intensive Opportunity Program/Care Model 2.0: Complex care management program includes the following:

- Evidence-based proprietary identification and stratification
- Target populations are members who have:
  - 2 or more disease states
  - Inpatient stay(s) within the last 90 days
  - Been discharged from inpatient psychiatric or substance abuse hospitalization
  - Been at risk for inpatient psychiatric, drug overdose or substance use rehospitalization
  - High dollar claims of over $50,000 in 6 months
  - High-risk pregnancy
  - High-risk neonatal intensive care unit
  - Impact Pro (IPRO) highest risk score for “affected” care management
  - Been engaged in other levels of service or identified through other means and can be escalated to this level based upon internal consultation with local clinical experts
  - Been identified as high-risk and have been provided a primary point of contact for clinical complex care management with a goal of identifying/addressing barriers and gaps in care and connecting members with PCP and/or specialists
  - Telephonic and/or field visits by behavioral health advocates (BHA)/RN
  - Been identified through the use of comprehensive assessment tools to identify the member’s physical, behavioral and social determinants of health needs
  - Care coordination driven from a defined plan of care
  - Locally-based interdisciplinary teams

Chronic Illness Program/Care Model 2.0 Extended:

- Provide emerging-risk members with non-clinical care management with a goal of identifying/addressing barriers and gaps in care and connecting members with PCP and/or specialists to lower their risk level and/or prevent moving to a higher risk level
- Target population is members with:
  - Increasing health services or emergency services utilization
  - Emergency utilization at least 3 standard deviations outside of the mean
  - Evidence of pharmacy non-compliance for chronic conditions
  - Recent discharge from an institution of mental disease (IMD)
  - Serious mental illness (SMI) who do not qualify for Medicaid rehabilitation option (MRO)
  - Healthy or rising-risk pregnancy
  - IPRO emerging-risk score for “affected” care management
  - Telephonic and/or field visits
    - These visits will be completed by community health workers (CHWs) and/or BHA/RNs
  - Care coordination driven from a defined plan as outlined by the member
  - Evaluation for referral to peer support services (PSS) or for specialized clinical interventions

Maternity modernization program (formerly known as Healthy First Steps)

Program enhancements have been designed with 3 primary objectives, with the goal of improving maternal and child health outcomes, including doula services and the following:

- Redefine who we classify as "high-risk" to drive efficiencies and effectiveness of care management
- Improve where and how we identify, outreach, engage and route members to needed care/services
- Modernize offerings to stay competitive and meet member communication expectations

	Healthy First Steps – current state	Enhanced Healthy First Steps – future state
Identification	• 3 processes to identify pregnancies	• 1 source of truth for pregnancy identifications (5% more identifications; 10 days earlier)
Stratification	• 2-tier strafification (healthy, high risk) • General clinical risk factors • initial stratification upon identification	• **3-tier stratification** (healthy, rising, high risk) • **Pregnancy-specific risk factors** • **Monthly re-stratification**
Member outreach & enrollment	• Maternity member services (HARC) auto-dialer outreach	• HARC to support **demographic research** for UTR members • Re-stratification based on member's **adherence to care plan**
High risk care management (RNs)	• Transactional care menegement • Managing .30% of pregnant members • Manual reviw of caims/other to understand need	• **Impactable care management** • Managing <20% or pregnant members • Visibility of risk factors from IPRO
Management of rising risk/healthy (CHWs)	• Varied across health plans	• Focused intervention for **rising risk BIPOC population**
Digital intenvetion	• HFS rewards	• Expanded digital offering to include HFS Rewards, Care Angel (artificial intelligence outreach) & member app (2022)
HFS training	• Multiple training sources • Focused on processes, job aids & systems	• Maternity/NICU add-on to core training curriculum • Increased focus on health disparities & OUD/SUD • National training for HSD, MCHC, HARC & NASU Teams

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 HFS 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 childcare 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 and 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 CHWs. The health plan's maternal and child health program coordinator will refer members to CHWs that are high-risk and unable to reach via initial outreach or previously engaged, but now lost to care. 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 (MCHP) 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 health care professional, will receive:

- A welcome letter with information that tells her about the HFS 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 HFS 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 HFS 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 HFS 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 MCHP coordinator shall monitor high-risk members regularly via reporting, automated systems alerts and other standard monitoring methods to ensure program requirements are being met.

Maternal opioid use disorder/substance use disorder

Pregnant members with OUD/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 day 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 health care professionals 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.

Health care professional support

- Enhance relationships and provide support to network health care professionals/practitioners by:
  - Improving health care professional and practitioner satisfaction by offering a comprehensive suite of tools, education and support in the delivery of care to pregnant women and their babies
  - Adopting and disseminating nationally accepted pregnancy and early childhood clinical practice guidelines
  - Establishing further collaborative relationships with network health care professionals 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
  - Collaborating with obstetric health care professionals on data exchange regarding patient adherence to treatment plans, condition monitoring and management of comorbid conditions
  - Monitoring performance of practitioners and health care professionals against evidence-based guidelines

Annual updates are given to health care professionals 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 health care professional who has a member receiving care management services receives a letter of notification with staff contact information and an invitation to participate in the HFS plan of care. The care manager may contact the PCP or subspecialist to design interventions for the member. Care managers may contact the obstetrical health care professional to report concerns, barriers to care, or for recommendations and assistance with completing interventions. HFS 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 HFS staff and obstetrical health care professionals 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. Health care professionals 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 UM department functions as a multi-disciplinary 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 health care professionals.

UnitedHealthcare behavioral health

The State of Maryland designated Optum Maryland as the health care professional of specialty behavioral health and substance abuse services as an administrative services organization (BH ASO) effective 2020. UnitedHealthcare does provide an integrated Behavioral Health Case Management service under the Care Model 2.0 Program. Our behavioral health advocate leads efforts towards 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 Plan of Maryland collaborates with the BH 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 tools, Community Care, ICUE, Microsoft's suite of applications (Word, Excel and Power Point) outreach database. A health risk assessment reporting program is utilized to tailor the enrollment data received from the MDH to conduct outreach within required timelines.

The desktop working system employed by 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, health care professional 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, also member and health care professional demographics to enhance appointment scheduling. The Hotspotting data software captures 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 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 2022, UnitedHealthcare shifted focus to work closely with health care professionals and Federally Qualified Health Centers (FQHCs) along with our community partners to promote healthy lifestyles and getting needed care. 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 2022 community activities included:

- AdultFit – in person
- Baby shower – in person and virtual
- Back-to-school event – in person and donations
- Chef story time – virtual clinic day – in-person community event – in person, virtual and donations
- Cooking demonstration – in person
- COVID-19 clinic – in person
- FamilyFit – in person and virtual
- Farmers market – in person
- Federally Qualified Health Center week
- Food distribution – in person KidFit – virtual
- Health care professional event – in person
- Local health improvement committee (LHIC)
- Member appreciation – in person
- Member orientation – in person

- National Doctor's Day
- National Nurse's Day
- Wellness forum – in person and virtual
- UnitedHealthcare Community Plan Consumer Advisory Board (CAB) meeting – virtual
- UnitedHealthcare Community Plan Community Advisory Committee (CAC) meeting - virtual

A series of health education sessions focusing on good nutrition, healthy eating, women, prenatal, immunizations, well-child visits, lead screenings, stress management, and cold and flu screenings. 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. UnitedHealthcare participation with community partners and health care professionals will continue in 2023.

2022 event locations and the number of events held in each area:

- Prince Georges – 58
- Baltimore City – 34
- Baltimore County – 32
- Howard – 20
- Charles – 19
- Washington – 12
- Montgomery – 11
- Harford – 4
- Anne Arundel – 2
- Carroll – 1
- Cecil – 1

Consumer advisory board

The UnitedHealthcare Community Plan Consumer Advisory Board 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 virtually 6 times a year using the Teams platform and have 9 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. Board 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 2022 were:

- 2021 member experience survey results
- Stretching your food dollars
- Healthy cooking
- Autism 101
- Doula and home-visiting services
- Summer safety
- Preserve your health through self-care
- CAB survey results
- Assessing member understanding

Community advisory committee

In 2022, UnitedHealthcare continued to improve our health services through our CAC. The Community Advisory Committee is dedicated to local health departments (LHDs), health care professionals, 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 CAC was hosted virtually in 2022.

VI. Partnerships with local health departments

UnitedHealthcare collaborates with the 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 health care professional 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 to locate the member. United Healthcare 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 health care professional

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

United Healthcare procedures regarding health care professional outreach is provided during Joint Operations Committee (JOC) meetings and town hall meetings. Network health care professionals are encouraged and expected to review the provider care manual that outlines their responsibilities as it relates to caring for the Medicaid population and interacting with their provider advocate to obtain information on benefits, regulations, policies and procedures for referral/pre-authorizations, drug formulary etc. Health care professionals are also encouraged to participate in town hall meetings that offer health care professional-specific information on a variety of topics. More information can also be found at **UHCprovider.com.**

VIII.Conclusion

Evaluation of the outreach program

Outreach approaches are monitored, data analyzed and appropriate interventions deployed. The current approaches and partnerships are to 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

2022 local and national outreach activities

Activity	Volume
EPSDT preventive letters	129,521 letters mailed
Live telephonic outreach by vendor	72,343 unique member calls
HFS rewards program	52,611 program mailers to members 6,304 members registered for the program 6,640 deliveries • 58% completed prenatal visit • 28% completed postpartum visit
Member rewards program for gap closure	43,386 mailers to members
Telephone outreach interactive voice recordings (IVR) calls	42,712 IVR calls
Telephone outreach	39,958 local outreach calls
Letters when unable to reach by phone	34,148 “Sorry we missed you” letters mailed
Disease management brochures **(Asthma, heart failure, COPD, coronary artery disease and diabetes)**	6,897 disease-specific mailers (Jan.–Sept. 2022)
Appointment scheduled by outreach agents	614 appointments scheduled

Note: Volumes are YTD (Sept. 30, 2022)
The pandemic has been a barrier to scheduling appointments regardless of outreach activities.

The 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.

The outreach activities 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, 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.

The first half of 2022 outreach was challenging due to COVID. Members did not want to complete a visit for fear of exposure to the COVID-19 virus.

During live calls, members were informed that telehealth visits were an option to an office visit if immunizations or screenings were not needed based on age-specific requirements. For members with complex care needs or those designated under SSI, the special needs coordinator made calls to identify needs that could be met via telehealth visits or informed of community resources as deemed appropriate. In the second half of 2022, based on the changes of CDC guidelines, several activities were resumed such as health community events and clinic days.

In 2023, outreach activities will continue. Modifications may be implemented to address the State's COVID status. The focus 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 member outreach.

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