Maryland
2023 - 2024 Outreach Program Plan

Approved:

Director, Quality Management	November 2023
Chief Medical Officer	November 2023
Quality Management Committee	

Table of Contents

I. Overview of UnitedHealthcare Community Plan

A. Mission

UnitedHealthcare is a business unit of UnitedHealth Group. UnitedHealthcare is one of nine 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 Plan 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 170,388 members. The Outreach Program is a member and provider centric model designed to use several data sources to identify members in need of care 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 identifies and address barriers to care or social determinants of health.

C. Member and Provider Outreach Programs

New Enrollee Outreach

Outreach begins with a 'Welcome Call" to new enrollees informing them of the necessity of scheduling and completing an Initial Health Appointment with their primary care provider (PCP). If the member has not been reached, a follow up outreach call is completed at the local level to ensure member is engaged and assisted with scheduling initial appointment with their care provider.

UnitedHealthcare's Network Management Partnership

UnitedHealthcare Community Plan is in partnership with UnitedHealthcare Network Management with the goal to help with adherence to State of Maryland quality performance criteria and provide support resources. The partnership 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, and 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 Healthcare Effectiveness Data and Information Set (HEDIS®) or State provided data, members are identified for outreach. Claims and encounter data is used to identify members in need of services. 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, Health Education, Special Needs, Member Services, Utilization Management 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 providers by the Senior Quality 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 providers '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.

UnitedHealthcare's current multifaceted outreach efforts, tracking databases as well as continued evaluation of strategies, will continue in 2024. 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 1/2023 – 10/2023

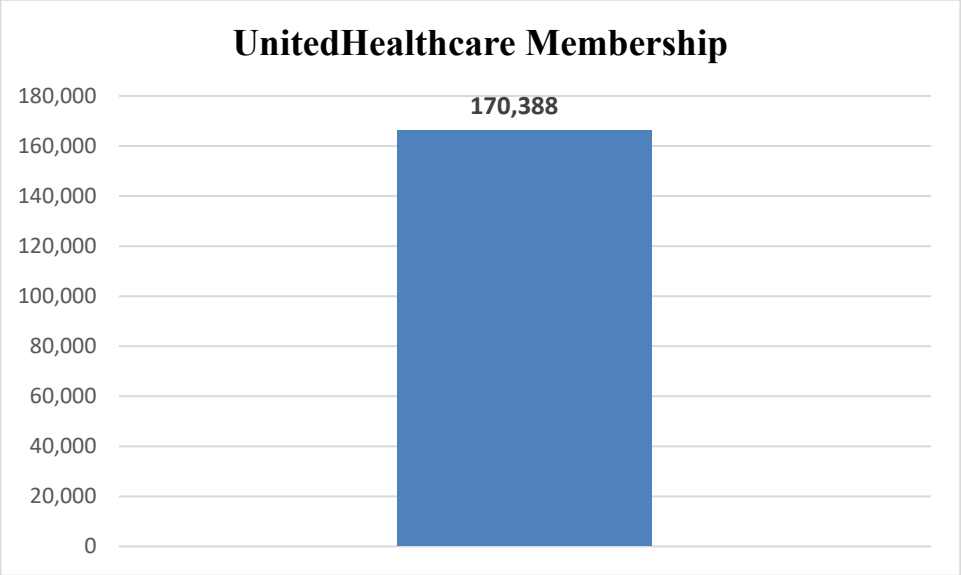
A. Population Assessment

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

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

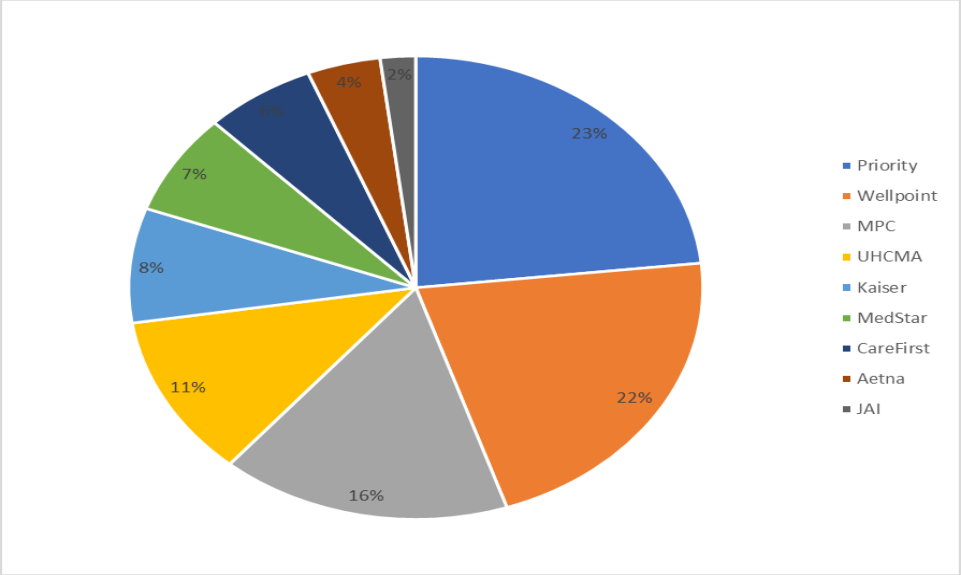
Special Needs Population	CY2021	CY2022	CY2023
Children with special health care needs	2,569	2,580	2,957
Individuals with a physical disability	2,625	3,230	4,313
Individuals with a development disability	4,510	4,921	6,680
Pregnant and postpartum women	3,717	3,876	4,061
Individuals who are homeless*	2,397	1,978	2,062
Individuals with HIV/AIDS	1,090	1,023	1,167
Children under State Supervision	2,432	2,302	2,144

Figure 1: Membership



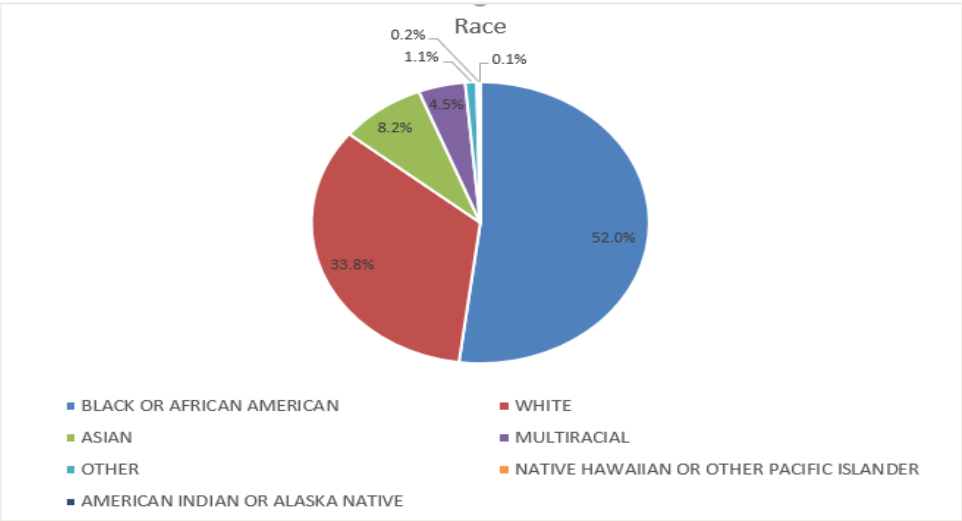
Data Source: SMART: January 2023 – October 2023

Figure 2: Medicaid Managed Care Market Share

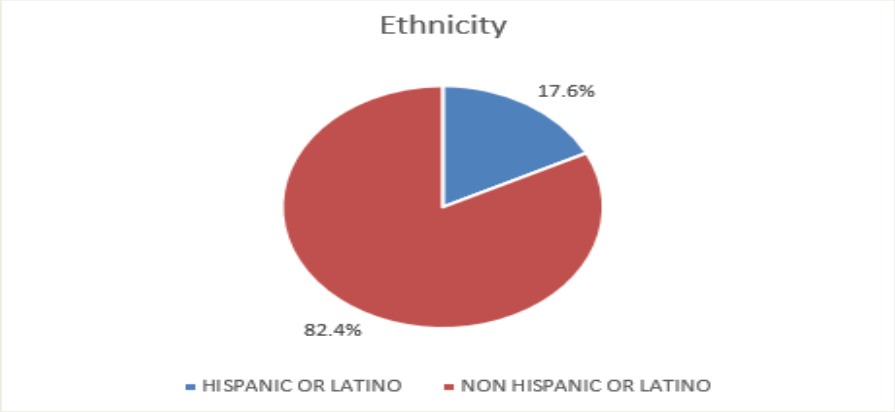


Data Source: SMART: January 2023 – October 2023

Figure 3: Membership Race and Ethnicity

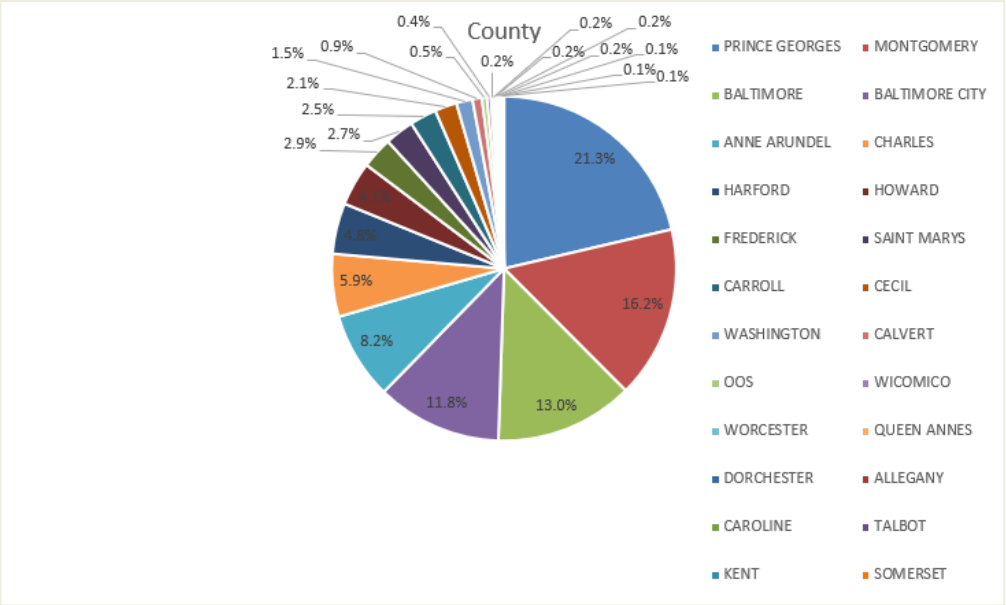


Data Source: SMART: January 2023 – October 2023



Data Source: SMART: January 2023 – October 2023

Figure 4: Membership by County



Data Source: SMART: January 2023 – October 2023

B. Common Health Diagnoses

Based on the varying diagnoses for the three settings, different outreach and care management strategies are deployed. The following is an analysis of UnitedHealthcare's most common inpatient, outpatient, and Emergency Department utilization by diagnosis:

Top 10 Inpatient Diagnosis		Top 10 Outpatient Diagnosis
1. Single Liveborn Infant Deliver; Vaginally		1. Contact with and (suspected) exposure to COVID-19
2. Single Liveborn Infant Deliver, Cesarean		2. Acute Pharyngitis Unspecified
3. Sepsis Unspecified Organism		3. Obstructive Sleep Apnea
4. Post-term Pregnancy		4. Encounter General Adult Med Exam
5. Maternal Care for Low Transverse		5. Encounter for Screening for COVID-19
6. Abnormal Fetal Heart Rate		6. Encounter Rtn Child Health Exam
7. Muscle Weakness Generalized		7. Essential Primary Hypertension
8. Morbid Severe Obesity		8. Encounter GYN Exam General Rtn
9. Acute Respiratory Failure w/ Hypoxia		9. Acute Upper Respiratory Infection
10. HB-SS Disease with Crisis Unspecified		10. Encounter Screening Mammo Malignant

Top 5 Emergency Department Diagnosis
1. Other Chest Pain
2. Acute Upper Respiratory Infection
3. Chest Pain Unspecified
4. Headache Unspecified
5. Viral Infection Unspecified

C. Quality Performance

Maryland Department of Health (MDH) measures UnitedHealthcare's performance individually and all Managed Care Organizations (MCOs) collectively through several initiatives, including audit and analysis of the Medicaid HEDIS® and Maryland State Population Health Incentive Program (PHIP) encounter reports. In addition to the clinical inpatient, outpatient, and Emergency Department outreach opportunities identified, the following HEDIS® and Maryland State Population Health Incentive Program (PHIP) measures are tracked to help ensure initiatives are implemented to close gaps in care:

Quality Performance Measures	
Well-Child Services (infant, toddler, adolescent)	Controlling Blood Pressure
Immunizations	Woman Health Screenings
Comprehensive Diabetes Care	Asthma Medication Ratio
Postpartum Care/Timeliness of Prenatal Care	Lead Screening
Supplemental Security Income (SSI) - Adult and Child	Risk of Continued Opioid Use

Managed Care Organization Dimensions	**Performance Measures**	**UnitedHealthcare Rate HEDIS® Measurement Year 2021**	**UnitedHealthcare Rate HEDIS® Measurement Year 2022**
Access to Care	% of adolescents 13 years of age during the measurement year who had one dose of meningococcal vaccine and either one Tdap or Td vaccine by their 13th birthday	87.83%	88.5%
Access to Care	% of SSI adults enrolled 320 or more days with at least one ambulatory service during the year	78.6%	76.2%
Access to Care	% of SSI children enrolled 320 or more days with at least one ambulatory service during the year	78.5%	75.2%
Access to Care	% of deliveries by a pregnant who had as postpartum visit on or between 7 and 84 days after delivery	77.37%	74.9%
Use of Services	% of children ages 12-21 receiving at least one well-child visit with PCP during the year	12-17 yrs. 62.74% 18-21 yrs. 41.75%	59.1% 38.1%
Use of Services	% of children ages 3-6 receiving at least one well- child visit with PCP during the year	3-11 yrs. 68.21%	64.8%

Effectiveness of Care	% of children who turned two and who received combo 3 (all childhood immunizations) by their 2nd birthday	39.9%	67.3%
Effectiveness of Care	% of children who turned two and who received lead testing by their 2nd birthday	71.07%	60.0%
Effectiveness of Care	% of women ages 21-64 receiving at least one PAP test during the last 3 years	59.12%	59.7%
Effectiveness of Care	The percentage of women 50 – 74 years of age who had a mammogram to screen for breast cancer.	57.25%	59.7%
Effectiveness of Care	% of diabetics that received a dilated funduscopic eye exam during the year	45.01%	50.8%

D. Identified Barriers to Care

Based on member and provider reports, UnitedHealthcare develops targeted outreach to reduce barriers to care and address social determinants of health. A number of strategies are employed to contact members 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 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

- Although COVID restrictions were lifted in 2023, members may remain concerned about exposure to the COVID virus as well as potential exposure to the respiratory syncytial virus (RSV). 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 or 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 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.

Provider Barriers

- Providers are trying to normalize their practices due to COVID-induced closure of satellite office resulting in an influx of patient from closed satellite offices and staffing challenged.
- 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 2024, UHC will continue its outreach efforts engaging our members and supporting the scheduling and keeping of appointment(s), address social or language/cultural barriers as well as social determinants of health, provide health education to support and promote good health and well-being.

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. UnitedHealthcare's 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 not limited to, the Departments of Quality Management and Performance (QM, Outreach and HEDIS® Clinical Quality Nurses), Marketing, Healthy First Steps, Customer Service, Special Needs Coordination, Hospitality Assessment Reminder Calls, Disease Management and Fulfillment, and Health Services, 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 ensure quality programs are aligned with regulatory and accreditation standards. The Director of Quality Management reports to Chief Executive Officer for the Maryland Community Plan to 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 Chief Medical Officer (CMO), Health Services, Medicaid Operations and Administrative Management to 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 Chief Medical Officer regarding quality of care issues.

Manager, Quality Field Operations (Formerly Clinical Quality Manager)
The Manager, Quality Field Operations 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 Manager, Quality Field Operations works co-jointly with the Clinical Quality Manager, Health Educator and Clinical Operations Manager to maximize work efforts. The Manager, Quality Field Operations present 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, provides education on quality programs, and monitors and reports on key measures to ensure providers meet quality standards**.** The Quality RN reports to the Manager, Quality Field Operations.

EPSDT Quality Nurse
The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Quality Nurse is responsible for ensuring 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 not limited to offering education to support compliance of the Preventive Health Schedule, identify and share EPSDT on-line resources as well as confer with Chief Medical Officer to develop additional interventions to support compliance. The EPSDT Quality Nurse reports to the Manager, Quality Field Operations.

Clinical Operations Manager (formerly Outreach Supervisor)
The Clinical Operations Manager oversees the Clinical Administrative Coordinators, ensuring 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 UnitedHealth care's member compliance with preventive and chronic health services. The Clinical Operations Manager is also responsible for ensuring 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 providers; developing appropriate learning materials and programs; assessing program effectiveness and provide summaries of the program participation. The Senior Health Coach also writes topic-specific articles for the member and provider newsletter as well as 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.

IV. Tracking and Monitoring 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 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 on receiving the 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.

Members 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 UnitedHealthcare's 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.

Habitual No-Show or Missed Appointment
Provider practices are offered assist with outreaching to UHC members who are either a 'no-show' or who have missed three 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 three 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 UnitedHealthcare's 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.

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 on-site office visits. This report identifies member needing a well visit, an immunization, or a screening to close the gap in care.

Marketing
Marketing conduct community events as well as coordinate outreach activities to encourage gap closure with care provider 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 care provider.

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).

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.

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

Care Model 2.0 Extended:

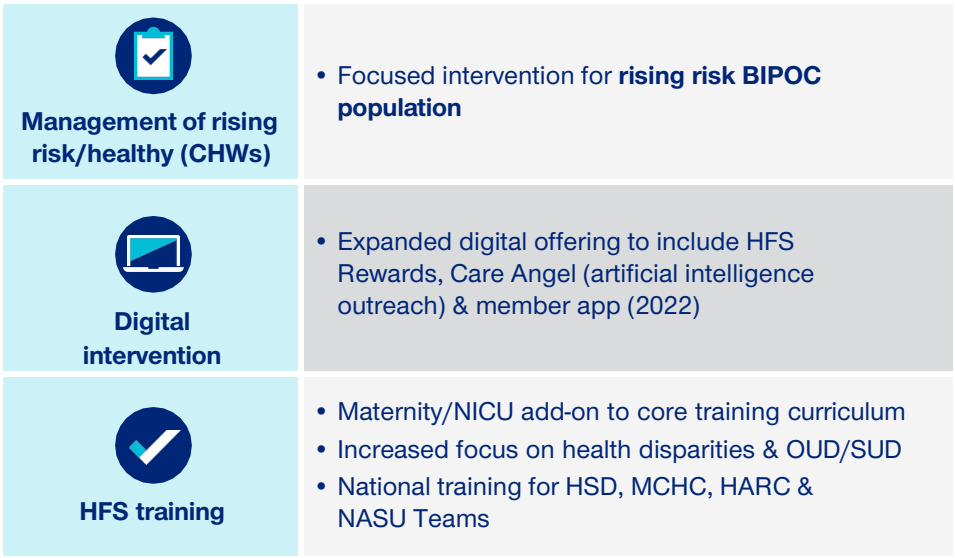
- Provide emerging-risk members with non-clinical care management with a goal of identifying/ addressing barriers and gaps in care and connecting members with PCP and/or specialists to lower their risk level and/or prevent moving to a higher risk level
- Target population is members with:
  - Increasing 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 Healthy First Steps™)

Program enhancements have been designed with three (3) primary objectives, with the goal of improving maternal & child health outcomes including Doula services:

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

	Enhanced Healthy First Steps
Identification	• 1 source of truth for pregnancy identifications (5% more identifications; 10 days earlier)
Stratification	• **3-tier stratification** (healthy, rising, high risk) • **Pregnancy-specific risk factors** • **Monthly re-stratification**
Member outreach & enrollment	• HARC to support **demographic research** for UTR members • Re-stratification based on member's **adherence to care plan**
High risk care management (RNs)	• **Impactable care management** • Managing <20% or pregnant members • Visibility of risk factors from IPRO



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 (OUD)/ Substance Use Disorder (SUD)

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.

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.

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 (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 United Community and State plan additionally collaborates with the BH ASO to coordinate care through formal rounds and direct collaboration leveraging the behavioral health advocate.

Customer Service Department

United Healthcare 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's 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 Power Point), Outreach database. A Health Risk Assessment reporting program is utilized to tailor the enrollment data received from the Maryland Department of Health (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, 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 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 2023, UnitedHealthcare continued 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 2023 community activities included:
- AdultFit – in person
- Baby shower – in person and donations
- 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 orientation – in person
- National Doctor'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 2024.

2023 Event Locations:

County	Number of Events
Prince Georges	34
Baltimore City	32
Baltimore County	29
Howard	16
Montgomery	16
Washington	5
Carroll	2
Harford	1
Anne Arundel	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 11 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 2023 were:

Topics Discussed at the 2023 Consumer Advisory Board Meeting:

- 2022 member experience survey results
- Abilities Network Project
- Maryland Healthy Smiles dental benefits overview
- March Vision benefit overview
- Health equity program
- Member grievance analysis
- Health equity evaluation
- Individual/Family Preparedness
- CAB survey results
- Assessing member understanding

Consumer Advisory Committee

In 2023, 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 2023.

VI. Partnerships 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 encourage 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. 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 2023.

VII. Role of the Provider

To ensure United Healthcare members have every opportunity to access needed health-related services, network providers participate in telephonic audits to ensure they are meeting Maryland Health Department appointment scheduling standards as well as EPSDT requirements.

United Healthcare 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. It is also encouraged they participate in Town Hall Meetings that offer provider-specific information on a variety of topics, and review bulletins on their website as well as articles in their newsletter.

VIII. Conclusion

Evaluation of the Outreach Program

Outreach approaches are monitored, data analyzed, and appropriate interventions deployed. The current approaches and partnerships are to 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 as well as social determinants of health.

2023 Local and National Outreach Activities

Activity	Volume
EPSDT Preventive Letters	48,233 Letters Mailed
Healthy First Steps & Baby Blocks Program	60,198 Program Mailers to Members 6,715 Members Registered for the Program 7,009 Pregnancies Completed • 44% completed prenatal visit • 15% completed postpartum visit
Telephonic Outreach IVR Calls	42,712 IVR Calls
Telephonic Outreach	39,964 Local Outreach Calls
Letters When Unable to Reach by Phone	28,185 "Sorry We Missed You" Letters Mailed
Disease Management Brochures (Asthma, Heart Failure, COPD, Coronary Artery Disease, and Diabetes)	6,673 Disease Specific Mailers (January – September 2023)
Appointments Scheduled by Outreach Agent	413 Appointments Scheduled

Note: Volumes are YTD (09/30/2023)

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.

The outreach activities were employed to engage members supporting scheduling and keeping their appointment with their care provider. The outreach agents performed live calls, which provided health information, explained the importance of keeping appointments, offered resolution to specific barriers including, language or cultural barriers, and social determinants of health as well as provided information on covered benefits. There were reminder IVR calls, letters sent, community events and community partnership meetings. The Outreach Work Plan is used to track outreach activities and presented to the appropriate Quality Committees.

Although COVID restrictions were beginning to lift in the first half of 2023, reaching the members continued to be a challenge as some members still had concerns of exposure to the COVID virus. During live calls, members were informed that telehealth visits was an option to an office visit if immunizations or screenings were not needed based on age-specific requirements. Needs of members in complex case management were addressed by the Case Manager. Based on the changes in CDC guidelines, several activities were resumed such as health community events and clinic days.

2024 Focus:
In 2024, member engagement activities will continue. 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.