4.02 PROPOSAL REQUIREMENTS FOR ALL MODELS

Table of Contents

4.02.01 Cover Letter (4 page maximum)

The cover letter must include the statements required under the Minimum Qualifications Section of this RFP (Section 1.04) and Proposal Contents (Section 1.08). The cover letter must also include the complete name and address of offeror's firm and the project lead, mailing address, and telephone number of the person the state should contact regarding the proposal. Proposals must be signed by a company officer empowered to bind the company. An offeror's failure to include these items in its proposal may cause the proposal to be determined to be non-responsive and the proposal may be rejected.

April 27, 2017

Department of Health and Social Services
Division of Finance and Management Services
333 Willoughby Ave., Room 760
Juneau, AK 99801

Attention: Jon Geselle
Request for Proposal (RFP) Number: 170007291
RE: Medicaid Coordinated Care Demonstration Project

Dear Mr. Geselle:

UnitedHealthcare Insurance Company (UnitedHealthcare) respectfully submits this Medicaid Coordinated Care Demonstration Project (CCDP) proposal in response to RFP 170007291. We are excited to offer a managed care organization (MCO) model for the CCDP, enabling us to collaborate as a partner with the Department of Health and Social Services (the Department, or DHSS) to support Alaska's goals of increased access to health care, improved health outcomes and reduced costs.

We provide the array of information required of us as outlined in Sections 1.04 and 1.08 of the RFP. Underlying these statements is our overriding commitment to a partnership with the Department through which we can achieve Alaska's vision for the transformation of its Medicaid health care system. The opportunity is significant, as are the challenges to move from a fee-for-service (FFS) environment to one where incentives are aligned to foster integrated and collaborative care and cost-effective approaches to addressing physical, behavioral and social needs. As we discuss in our Section 4 response, we are positioned to deploy various mechanisms, including payment and delivery system innovations, that will improve population health, reduce inappropriate ER and inpatient admissions, and efficiently administer Medicaid benefits. We know that our efforts must be strategically calibrated to build trusting, partnership relationships with providers, communities and members. We must consider the practical realities of existing infrastructure and operational capacity across our network of providers, then provide guidance, resources and leadership to advance managed care capacity.

We understand DHSS will be undergoing an evolution in leading this significant transformation. In our view, our full partnership with the Department will provide a relationship in which the State's strategies and solutions can be collaboratively designed, developed, deployed and revised as necessary. Importantly, as an MCO with great depth of scope and experience in serving Medicaid, we can be a market-based solution for the CCDP, demonstrating how strategies for a transformed health care system can be achieved.

We believe strongly that our MCO model can uniquely address the State's overarching CCDP objectives in several critical ways that include:

- Fostering budget stability by assisting the State to predict and control its costs while limiting its financial risk

- Shifting accountability for managing the provision of services by individual providers and multiple programs from the agency to the MCO, holding the MCO accountable for demonstrating quality of care and cost containment through appropriate quality and utilization management
- Fostering innovation by offering a pathway to integration of various population and region-specific care models, delivery system options, and even cross-agency programs, building upon effective, evidence-based approaches
- Supporting the State and the delivery system with data and information infrastructure that is essential for understanding and managing the health risks of the State's population, formulating policy and demonstrating program effectiveness

As part of our continued commitment and partnership with the State, we believe transforming Medicaid members to an MCO will provide a critical keystone first step toward the Alaska Healthcare Authority and will give the state more leverage in the health care market. We look forward to working with the State to make the health care authority a reality.

SECTION 1.04 MINIMUM QUALIFICATIONS

In accordance with Section 1.04.01 of the CCDP RFP, we make the following statements:

1. We propose to provide an MCO model for the CCDP in response to this RFP.
2. As a comprehensive MCO model, our proposed project will include all nine of the elements listed in Section 3.01 of the RFP.
3. A description of how our proposed project will use telehealth to reduce costs and improve member health as required by Section 4.02.03.D is provided on pages 14 – 15 of our response to the RFP.

In addition, per Section 1.04.01 of the CCDP RFP, we further declare that:

1. We understand State funds are not available to support our up-front implementation activities, and we are proposing a project that does not require an investment of State funds in our design, development and implementation of the demonstration project.
2. We are not proposing a statewide model that includes behavioral health (BH) services.
3. We are aware of federal Medicaid policies related to American Indian/Alaska Native (AI/AN) populations, the current Federal Policy on Tribal Medicaid Reimbursement, and we understand the State's commitment to full implementation of that policy. We are committed to collaborating with the State and Tribal Health entities to optimize the Federal Policy on Tribal Medicaid Reimbursement.
4. All professional staff involved in the project have the appropriate professional licenses.

As per the requirements noted in 1.04.02, in that UnitedHealthcare proposes a MCO model, we declare:

1. Our proposal contains strategies to address regions of Alaska where geography and transportation systems create challenges with meeting the CMS travel distance standards for managed care plans.
2. We are making engagement efforts with every Indian Health Service, Tribal, Urban Indian Health (I/T/U) provider in Alaska, and will foster professional relationships that extend past an in-network status to drive toward comprehensive and culturally competent care and management of their AI/AN populations. As part of this effort, all

network contracts with I/T/U providers will include the Indian Health Services (IHS) Addendum to formalize our acknowledgement of Tribe sovereignty, and we have a single network contractor and a single provider relations representative that works with all I/T/U providers, providing dedicated resources familiar with tribal health.

3. We understand that 37 percent of Alaska Medicaid enrollees are AI/AN, and are exempt from mandatory enrollment in a managed care plan without a 1915(b) or 1115 waiver approved by the federal government.
4. We currently meet Alaska Division of Insurance certification requirements.

Per the requirements of Section 1.08 (a) Authorized Signature, with my signature at the end of this cover letter, I bind UnitedHealthcare to the provision of the RFP. In addition, per the requirements of Section 1.08 (b), with my signature, I certify that UnitedHealthcare complies with all of items A. through H. including:

A. The laws of the State of Alaska
B. The applicable portion of the Federal Civil Rights Act of 1964
C. The Equal Employment Opportunity Act and the regulations issued thereunder by the federal government
D. The Americans with Disabilities Act of 1990 and the regulations issued thereunder by the federal government
E. All terms and conditions set out in this RFP
F. A condition that the proposal submitted was independently arrived at, without collusion, under penalty of perjury
G. That the offers will remain open and valid for at least 275 days
H. That programs, services and activities provided to the general public under the resulting contract conform with the Americans with Disabilities Act of 1990, and the regulations issued thereunder by the federal government

Per the requirements of Section 1.08 (c), our vendor tax ID is 36-2739571.

Per the requirements of Section 1.08 (d), with my signature, I attest that neither the firm nor any individuals working on the contract have a possible conflict of interest.

Per the requirements of Section 1.08 (e), we have identified the following federal requirements that apply to our proposal, the evaluation or the contract:

- In general, the requirements of 42 CFR 438 applicable to MCOs pertain to this proposal. In accordance with 42 CFR 438.6(f), all MCO contracts must also comply with all applicable federal and state laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1990 as amended, and Section 1557 of the Patient Protection and Affordable Care Act.

Additional Section 4.02.01 Cover Letter Requirements

In accordance with the requirements under 4.02.01, we provide the information requested regarding the complete name and address of our firm, the project lead, mailing address and telephone number of the contact person regarding this proposal.

Location
UnitedHealthcare, Alaska

310 K Street, Suite #700
Anchorage, AK 99501

Project Lead
Doug Bowes

310 K Street, Suite #700
Anchorage, AK 99501

Primary contact regarding the Proposal
Kevin Leclair

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We welcome your review of our full proposal, including the detailed descriptions of our proposed CCDP project. My signature reflects all of the statements and attestations in this cover letter, as well as our wholehearted commitment to working with DHSS to bring managed care to Alaska to meet the state's transformation goals.

Sincerely,

Jeri Jones
Regional CEO
1 East Washington St
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Phoenix, AZ 85004

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4.02.02 Introduction (1 page maximum)

Proposals must clearly identify which of the three models described in Section 4.01 above is proposed and explain the basis for concluding that the proposal fits within the identified model.

UnitedHealthcare proposes to partner with the Alaska Department of Health and Social Services (the Department, or DHSS) as a capitated MCO, offering a bold but strategically important approach to support the State's goals of increased access, improved health outcomes and reduced costs. Our proposal meets the key elements of the managed care model outlined in the RFP, specifically that: 1) we are a licensed health insurer in Alaska; 2) we are prepared to provide all Medicaid-covered services under a capitated PMPM payment arrangement; and 3) we are ready to assume full financial risk, beyond just upside risk, at the inception of the project. Beyond this, we strongly believe our comprehensive MCO model and approach to implementation — providing leadership, resources, a comprehensive and integrated approach to services, the ability to align and coordinate with Alaska's current health initiatives, and heightened accountability for financial management and quality of care — uniquely addresses the state's objectives for transforming Alaska's health system.

We know successfully making the transition from a FFS to a value-based, managed care environment requires incremental steps carefully calibrated to integrate population and region-specific care models with delivery system options. Payment models we have developed align capacity building incentives. In each Medicaid environment, we adapt payment models to be feasible and meaningful to providers, while budget neutral to the state. As an MCO, we are in a position to shift responsibility from the State for managing comprehensive services provided by multiple providers and programs, streamlining administrative burden while demonstrating improved quality of care, cost containment, and positive health outcomes among Alaska populations and communities.

We bring to the State and its diverse providers innovative, evidence-based care models and services adapted to address the distinct access challenges of Alaska's environment, as well as extensive quality improvement and utilization management resources and proven methodologies for measuring and addressing quality gaps in care. We support the State and the delivery system with a robust data analytics and information management infrastructure. This is critical for comprehensive, integrated care management, understanding and managing health risks and costs, formulating policy, and demonstrating cost-effectiveness.

Successfully transitioning to managed care and realizing the benefits in Alaska requires that we fully engage Alaska members, communities, providers and the Department as partners. We are prepared and eager for this relationship. Operating in Alaska since 1982, UnitedHealthcare has a dedicated health care delivery team that lives and works in Alaska, serving more than 121,000 Medicare & Retirement members, active duty military members, veterans, employer and individual plan members, government employees, and their families through our local offices. Building on this history, our MCO model will demonstrate value to the State through effective and comprehensive population health management, proactively addressing the needs of our Alaska Medicaid members spanning age and program eligibility categories (e.g., families, Denali KidCare, Medicaid Expansion, long-term care participants and individuals who are dually eligible for Medicare and Medicaid).

Our administration of comprehensive benefits will prioritize member and provider empowerment and accountability. For members, we support their recovery, wellness, health literacy and personal responsibility. For providers, we foster their engagement in transformation by providing capacity-building supports that bring tangible rewards both financially and within their patient and community relationships.

4.02.03 Overview and Understanding (10 page maximum)

Proposals must provide a narrative overview of the project. Offerors must also discuss their understanding of the Alaska health care delivery system, Alaska's Medicaid program, and how the proposed project will promote the goals of Medicaid Redesign. Proposals must include the following items.

A. Provide a high-level description of the project, including a description of the organizational structure, and the innovative approaches proposed. Describe how the proposed project promotes appropriate access to quality person-centric care. Describe how the proposed project promotes the Medicaid Redesign and Coordinated Care Demonstration Project's objectives.

We propose to serve the Alaska CCDP as a Medicaid MCO offering comprehensive Medicaid benefits and services to all eligible populations within a defined service area under a capitated per-member-per-month (PMPM) arrangement with the Department. In making this proposal, we carefully considered the current health profile of the State's populations and Alaska's health care landscape. We recognize the magnitude of the challenges related to Alaska's distinct cultural norms, dispersed communities and barriers to services. However, we understand that the State is fostering Medicaid reforms through various strategies and initiatives, and that these initiatives will be integrated into an aligned system of requirements, incentives and strategies. Our MCO model offers a systematic approach to comprehensive population health management valuing local culture and values. We orient the delivery system around a holistic, robust primary care model that integrates BH, coordination of social supports, and person-centered, team-based care. As part of this offering, we maintain levels of care management for members with low, emerging and high health risks, complex health needs and high costs. Our approach is data driven, collecting patient-reported and claims information to understand both our members and our delivery system capacity. We will maintain an extensive Alaska database and provide a care management platform that supports holistic care management and information sharing among providers as well as continuous monitoring and analysis of quality of care gaps. We will develop a blueprint for supporting contracted network providers with data, care management personnel, assistance in developing coordinated relationships with specialists and ancillary services, and tools for expanding access to services. Our CEO, medical director and key staff in the Anchorage operations office will retain local oversight and accountability for service delivery and resource allocation, as well as integration and coordination of benefits, services and utilization management (UM). Our centralized operations achieve economies of scale and operational efficiency, while our local operations emphasize local knowledge to support members and providers in their transformational efforts. We anticipate hiring 80 – 100 Alaskans and Alaskan Natives, and we are exploring satellite offices in Fairbanks and Juneau.

Innovative approaches. Our innovations address critical, broadly recognized key domains of what constitutes quality, cost-effective health care. We empower members through:

- ***Healthify:*** A web-based, mobile-friendly application that connects members to community resources, empowering users to bridge the gap between health care and social needs.
- ***Health4Me:*** Through this free mobile application, members access secure health and wellness information and locate in-network providers or urgent care centers.
- ***Baby Blocks:*** The program rewards members for attending appointments during their pregnancy and into the first 15 months of their baby's life using mobile-optimized tools.

Care models: We improve outcomes and reduce overall costs through an integrated, recovery-oriented, ***whole person care*** that encourages and empowers members to actively participate in managing their health, as described in detail to our response to Section 4.02.03 C.

Healthy First Steps (HFS): HFS promotes healthy births, with additional focus on high-risk pregnancies. HFS identifies members early in their pregnancy to enable assessment and risk stratification for proactive assistance, outreach to and education of pregnant members.

Innovative payment model: We are at the forefront of payment and practice transformation, using a collaborative care model and innovative value-based payments (VBPs) that align provider financial payments with improved clinical health outcomes and lower costs. Please refer to Section 4.03.04 of this response for detailed VBP information.

Expanding access to care through telehealth/telemedicine: Project Echo® and remote, high-tech/high-touch combine vital signs (e.g., heart rate, blood pressure) telemonitoring and telehealth visits for high-risk OB members and those with chronic physical or BH conditions. Telehealth/telemedicine improves access to primary, specialty and BH services, reducing unnecessary inpatient readmissions and ER utilization.

Medication Reminders: *Medication Reminders* improve medication adherence by alerting members to the time and frequency their meds should be taken or refilled. Text messages can be a blend of automated and real-time messaging between care managers and members. *Medication Reminders* improved medication adherence by 12 percent in a Medicaid population.

Innovative care management platform: Our CommunityCare platform enables care plan and health data sharing among the member's care team, enhancing care coordination and quality monitoring.

Promoting access to quality person-centered care: We improve outcomes and reduce overall costs through our Whole Person Care model that provides integrated, recovery-oriented care that empowers members to actively participate in all aspects of managing their health, as described in detail to our response to Section 4.02.03 C. Our proposed MCO model and approach to primary care management achieves positive outcomes for members, especially those with complex needs such as individuals with BH and/or substance use disorder (SUD) and children with severe emotional disturbances (SED) through a continuum of community-based services that address housing, employment, criminal justice and other relevant issues.

Medicaid redesign and CCDP objectives: As the State anticipates seeking federal waivers and State Plan Amendments to further develop its services (e.g., health homes) and integrate BH along with other reform mandates called for by SB 74, our project presents a valuable opportunity for the Department to leverage our MCO experience, expertise and operations to advance the range of Medicaid redesign objectives and initiatives underway. We have full administrative capacity to immediately begin administering enrollment, provider contracts, utilization and quality management policies and processes, and provider and member services. We are prepared with the proven capacity to integrate and manage various configurations of provider practices and delivery system models, including contracting with coordinated care entities, and potentially health homes, as part of our overall provider network and service capacity.

B. Describe challenges to delivering accessible, high quality and cost effective care to Alaskans statewide (or in the proposed service area) and how the proposed project addresses these challenges.

The lack of long-term care options, a shortage of internal medicine, subspecialists, psychiatrists and qualified facilities throughout Alaska's non-urban areas create a unique level of complexity to providing timely access to quality health care. Medical evacuation and transport costs are exorbitant, and the weather can delay urgent and routine medical travel. Furthermore, the Alaska Federal Care Partnership reports that seven out of 10 Alaskans die from chronic disease, such as obesity, cancer, depression/suicide, or alcohol, tobacco and drug use. Our MCO model breaks through these barriers to quality health care delivery through remote monitoring and telehealth, integrating BH and SUD services, improving coordination of care and

non-emergency medical transportation (NEMT) services, and implementing in-home and community support services. Our MCO model will help to move health care delivery from an array of disconnected programs to a coordinated system with greater capacity and relevance for our Alaskan members.

C. Identify the elements from SB 74 (listed below) the project addresses, and describe how the project addresses each identified element. Note that SB 74 requires CCDP projects to include a minimum of three of the following nine elements. Please refer to the Definitions Section of the RFP for clarification of terms (Section 2.02).

Our comprehensive managed care model addresses all nine elements identified in SB 74.

1. Comprehensive primary-care-based management for medical assistance services, including behavioral health services and coordination of long-term services and support;

As part of our comprehensive managed care design, we connect individuals to PCPs and help provider practices build their teams to meet each individual's holistic needs. Our evidence-based approaches include integration models, such as co-location of primary care and BH and supplementing our care team with peer supports and community health workers (CHWs) to verify individuals receive comprehensive primary-care-based management. Core elements of our care model include:

Primary care engagement: Our model promotes a meaningful working partnership with the member and his/her own primary care team of medical, behavioral and community specialists. With every member interaction, we confirm the member is actively engaged with his/her PCP and primary care team. Our model supports the PCP to enhance, coordinate and monitor the member's care. It incorporates patient-centered medical home (PCMH) principles, confirming that provider practices address the level of risk and intervention required for individuals with different and fluctuating levels of complexity. We build advanced primary care capacity at the provider practice level, including the ability to coordinate member care and deliver integrated physical health, BH and long-term services and supports (LTSS). We provide distinct supports that help practices develop and improve their capacity to provide advanced team-based care coordination, including transformation consultants who work with the practice and technologies that support its ability to deliver population health management.

Integrated, field-based, team-based approach: We use an integrated health risk assessment and an evidence-based, stratification process, which blends medical risk and behavioral, pharmacy and social risk elements to identify and engage members in care coordination. A collaborative care team, comprising a RN, a licensed BH care manager and a CHW, coordinates, enhances and monitors service delivery to improve member outcomes and reduce risk. It collaborates with the PCP to coordinate care for members at highest risk.

Maximizing coordinated delivery of medical and BH services: We recognize the prevalence and impact serious BH issues can have among members, which is why we address medical and BH risks during screening, assessment and care coordination. Our MCO model incorporates best practices to address each member's medical ***and*** BH priorities:

- Encourage integration of BH at primary care through co-location, telehealth and using new payment mechanisms for BH services provided under CMS' new psychiatric Collaborative Care Model (CoCM), discussed in our response to Question C.9.
- Integrate initial and comprehensive assessments to identify the member's social, behavioral, medical and functional issues and needs, including the need for condition-specific BH screenings and more in-depth BH clinical assessments.
- Field-based care teams that include an RN and a licensed BH advocate who consult each other to identify and address the needs of individuals with comorbid conditions.

- We use our *Behavioral Health Toolkit for Health Care Professionals*, which includes evidence-based tools (e.g., assessments), to help non-BH providers guide individuals who screen positive for a BH condition.

Coordination of LTSS: Our comprehensive managed care model offers significant potential for improved outcomes for members receiving LTSS. To understand an individual's holistic needs, our model includes the benefit structure of home and community-based services (HCBS) waivers coordinated with the member's medical, BH and social needs. Our integrated approach maximizes nursing facility (NF) diversion activities to maintain community living, enhancing quality of life and providing cost-effective care delivery. For example, for a member hospitalized with a hip fracture, we can coordinate increased in-home services upon discharge to avoid a NF admission. Our collaborative work with NFs allows us to confirm that members living in NFs have appropriate services and supports and identify individuals who wish to return to the community. Our comprehensive transition planning process manages the transitions to a community setting in alignment with the member's community integration goals.

2. Care coordination, including the assignment of a primary care provider located in the local geographic area of the recipient, to the extent practical;

Our managed care approach allows us to capture and share extensive member data, and through our innovative tools, provide a unique ability to support care coordination. We ensure easy exchange of health information for care coordination through our provider portal tools, including sharing of inpatient admissions and ER utilization near real time through admission, discharge and transfer (ADT) alerts, preventive care needs — including due or overdue EPSDT services, individualized care plans and member goals. Care coordination activities include facilitating delivery of services **and** the information exchange necessary for those services. This may include sharing a treatment or care plan and communicating a member's goals. Vital to effective care coordination and central to our program design is promptly assigning the member to a PCP located in his/her local geographic area. We use our Provider Recommendation Engine (PRE) to auto-assign PCPs to new members when a designated PCP is not present on the state enrollment file. PRE bases the auto-assignment upon criteria such as historical provider relationships, family member PCP assignments, geographic proximity, age and gender. Members can change PCPs during the new member welcome call, by calling our *Advocate4Me* member services center, through the member's care manager, via our secure member website, *myuhc.com,* or by initiating a request through our mobile application, *Health4Me*.

3. Health promotion;

Health promotion, as part of a population health approach for individuals at all risk levels, is core to our comprehensive managed care design. We use various innovative modalities and programs to engage and support members in taking responsibility for their health, improve their ability to manage specific conditions and seek out preventive care. For example, we help members seek recommended care and preventive services through our member app, *Health4Me,* and our innovative maternity app, *Baby Blocks,* which helps pregnant members receive recommended prenatal and infant well care. Based upon evidence-based research that suggests texting approaches to health education are effective, we implemented *MyHealthLine* texting programs for tobacco cessation, diabetes, kids' health and adult health. In alignment with the *Healthy Alaskans 2020* priorities, we will offer disease management (DM) programs and implement targeted education for pregnancy, tobacco cessation, obesity/healthy weight, depression and SUD. Our *Member Handbook* and our quarterly member newsletter also provide health education and health promotion. In addition to mailings or web-based education designed for Alaska, we will implement targeted DM education through our care coordination teams.

4. Comprehensive transitional care and follow-up care after inpatient treatment;

Comprehensive transitional care supports individuals when they are most at risk and the timely support of care transitions is a key element to our managed care approach. Our evidence-based design includes ***proactive discharge planning***, which begins the first day of admission and continues through the critical days post-discharge. It involves the member, family, caregiver, our inpatient case manager (ICM), care coordinator, attending physician, hospital case manager, PCP and others as part of an interdisciplinary team (IDT). The ICM leads the collaborative effort by identifying post-discharge issues through a comprehensive assessment; and develops a discharge plan to deploy services and supports upon discharge. Similar to our Hawaii health plan, we expect that Alaska transitional care will include coordination with out-of-state hospitalizations, especially for complex BH admissions. We have processes and experience coordinating transitional care across state lines to provide safe and effective follow-up care. Our ***transitional care management (TCM)*** program enhances discharge planning by implementing high-touch, high-intensity care management activities in the critical 30-day period after discharge. Based upon the Coleman Model, the care coordinator engages the member in TCM activities at crucial transition points, such as conducting a post-hospital assessment within three days and verifying a PCP or BH follow-up appointment is scheduled to occur within seven days.

5. Referral to community and social support services, including career and education training services;

Research and our own experience tell us that intense use of services is often not due to illness severity, but to barriers to accessing care. Social determinants are a significant driver of an individual's health and it is critical to implement a comprehensive approach to identifying and addressing them. Our comprehensive managed care model includes supports and integrated approaches to identify and address social determinants through the following core elements:

Identify and incorporate community resources into the care plan: Through the new member welcome call and initial risk assessment, we collect information that provides a holistic view of the member's overall health state, including social determinants. Our care teams identify local community resources that meet members' needs using their neighborhood knowledge, discussions with the IDT and using *Healthify,* an innovative web-based, mobile-friendly application that connects the care team to relevant community resources. The care team collaborates with community-based organizations (CBOs) to support members' needs, documents these services and supports in the care plan, and authorizes and coordinates, as appropriate, these services with the member's BH, medical and LTSS services.

CHW outreach to meet members where they live: We employ CHWs, who live in the communities where they work, to serve as the main point of contact responsible for outreach to the member and family. The CHW is cross-trained in medical and BH conditions, and he/she helps to identify the member's barriers to care using our Access to Care Assessment. Once identified, the CHW supports the connection to needed community and social support services.

Develop relationships with CBOs: We have substantial experience developing diverse community relationships with agencies and CBOs to provide community-based services to our members. For example, through our Texas STAR+PLUS program, we partner with at least 320 CBOs, such as Area Agencies on Aging, food pantries and Head Start programs. Our leaders sit on the boards of several CBOs to understand their needs and identify ways to collaborate. We have begun identifying Alaska CBOs that can help meet Medicaid member needs, building on our existing CBO relationships through our Military & Veterans line of business in Alaska, such as the Armed Services YMCA, Alaska Airport Lounges and the Alaska Fisher House.

Referrals to career and education training services: Because we understand that career and education can be an important step to transitioning off Medicaid, we will employ a social supports specialist to help Alaskans access career and education training services. Our

specialist will have extensive experience as an employment network provider and will understand employment benefits the plan must administer. He/she will engage employment network providers and agencies, Workforce Initiative Boards and Employment First organizations. The specialist will support employment provider-network development, provide education monitoring, and educate and support the care team and members. The care team, supported by the specialist, will help members identify education and training programs and connect members to work and educational resources, such as funds/offerings available through State workforce-development programs, community colleges or job placement services.

6. Sustainability and the ability to achieve similar results in other regions of the state;

We will coordinate care for Alaskans in the boroughs of Anchorage and Mat-Su, Fairbanks and Juneau. As we improve health care delivery in these boroughs, we will partner with the State to determine when and how to expand to other Alaska regions. We have developed a variety of care coordination approaches in other states that led to sustained improvement in key measures. Some recent examples that we intend to bring to Alaskans include:

Improve care coordination: Our Whole Person Care model directs our care teams to monitor each member's health status and implement targeted, timely interventions to prevent an escalation of the member's utilization. Our Medicaid and Dual-eligible Special Needs Plan (D-SNP) experience demonstrates our model's improvements in key outcomes. In 2015, we implemented our model in three states, leading to year-over-year reductions in acute inpatient admissions in the targeted population compared to 2014. In Kansas, we saw a 31 percent reduction, in Maryland, a 12 percent reduction, and in Florida, a 24.4 percent reduction.

Reduce inappropriate ER use: Building on whole person care ideals, we improve access to primary care and BH services and provide members with information about ER alternatives, such as access to RNs, that can help reduce inappropriate ER use. We measure the overall effectiveness of our efforts using quality and utilization metrics (e.g., HEDIS) and through collaboration with our providers. In 2015, our national rate of ER visits declined 3.1 percent.

Targeted intervention for persistent high utilization: We identify members with persistent high utilization and implement timely, targeted interventions to uncover root causes and address the issues leading to the persistent high utilization. Our model focuses on PCP awareness of a member as a high utilizer, engaging the member to mitigate inappropriate use of services and improving medical and BH outcomes. In the first six months of 2016, across 14 state Medicaid markets, our intervention efforts resulted in 1,997 avoided admissions and 246 avoided ER visits resulting in overall savings of more than $25 million or $91 PMPM. Our efforts have saved $5.16 million redirecting members to their PCP instead of the ER or hospital.

Rebalance the LTSS system between HCBS and institutional care: Knowing that most individuals living in an institutional setting want to return to their communities, we developed and implemented a comprehensive *Transitions to Community Living* program. We identify members desiring to return to the community from an institutional setting, develop a transition plan, assure the continuity of the member's care during transition, and identify and deliver services and supports to maintain the member in his/her new community-based care setting. Using our *Transitions to Community Living* transition planning process, we transitioned 1,878 members across six of our LTSS programs from an institutional setting to the community in 2016.

Manage pharmacy spend: A therapeutic class that has seen significant changes and increased cost in the past three years is hepatitis C. The latest therapies available have high success rates in managing the disease. However, it is critical that members remain compliant with their treatment plan, and consistently report side- effects and receive support for clinical or psychosocial issues. To assist with this, our specialty pharmacies regularly outreach to these

members to provide support and early intervention. They contact members at least monthly, discuss their compliance with the treatment regimen, and schedule additional follow-up calls to address concerns. We also engage each new hepatitis C member with a drug review incremental to that provided through prior authorization, as part of our care coordination approach from a pharmacist specialized in hepatitis C. In the first eight months of providing this service, we performed 3,877 hepatitis C consultations, which averted 885 unnecessary refills and achieved about $25 million in ingredient cost savings.

7. Integration and coordination of benefits, services, and utilization management;

Different from the Care Management Entity (CME) or Provider-Based Reform (PBR) models, integration and coordination of benefits (COB), services and UM are a core element of our MCO model. Our data warehouse will use service, COB, UM, social and functional data to support our risk stratification processes to provide an integrated population health view of the Alaska membership. Our clinical care management, quality management (QM), grievances and appeals, member services, provider services and health care economics teams collaborate to confirm medical, BH and functional resources are used in the amount, duration and scope necessary to achieve desired member outcomes. We collaborate to bring salient information and support to our care teams and providers through our integrated UM, QM and clinical care-management governance structure.

Our chief medical officer, health services director, QM director and UM director provide strategy and leadership for our clinical and UM/QM activities. We embed UM activities into our care coordination processes, such as discharge planning, TCM and pharmacy management. In each instance, medical directors and UM clinicians work closely with our care teams and providers to determine the medical necessity, appropriateness and cost-effectiveness of care provided to members. They work to avoid inappropriate use or duplication of services and assure members receive appropriate services and supports to close care gaps. We engage members in care coordination, if warranted, and manage care transitions. Our QM program uses critical evidence about health care patterns and practices to translate effective policies and procedures into action. For example, through provider profiling, our QM, clinical and provider services teams work with providers to close member care gaps and refer members to needed services.

8. Local accountability for health and resource allocation; and/or

We will create meaningful and impactful local partnerships that address the unique needs and pain points of Alaska’s health system at the community level, starting with local member and provider advisory councils. These advisory councils will serve to build a healthy neighborhood concept involving members and providers in being accountable for improving the health of members, improving care quality, reducing unnecessary utilization and measuring success. To address proper allocation of health system resources, we will proactively assist PCPs in practice transformation, which requires long-range commitment to culture change, time and business process reengineering. Our collaborative partnerships will include hospitals, community mental health centers (CMHCs), FQHCs, rural health clinics (RHCs), community health centers (CHCs), PCPs, physician extenders and specialists. Our local accountability approach will systematically link one or more PCP practices to one or more hospitals, safety net providers and BH providers in a local community. We will teach providers how to work within our Whole Person Care model to integrate health care delivery and population health management. Our locally based practice transformation specialists will help PCPs to connect with other clinicians, hospitals and specialists serving their patients in the same community. Our local accountability program leads health system and payment transformation across the continuum of care at the local level, with PCP practices at the heart of each community. We will submit an application and program model for our local accountability model upon award. We support the

Department's vision and guiding principle of transforming Alaska's Medicaid health system. UnitedHealthcare has extensive experience in this area; we currently serve more than 1 million Medicaid members through the accountable care communities we assembled in 21 states.

9. An innovative payment process, including bundled payments or global payments.

We are at the forefront of payment and practice transformation, using innovative VBPs that align provider financial payments with improved clinical health outcomes and lower costs. Throughout the pilot, we will offer VBP programs that reward providers for working collaboratively to coordinate and provide appropriate care for each member's situation, as well as drive positive population health outcomes. Because providers are at varying levels of practice size and sophistication, we offer a continuum of incentives that align with their willingness to enroll in an incentive plan, level of readiness and ability to meet performance and expected outcome goals. To help improve physical and BH care integration, we are also proposing to implement an innovative Collaborative Care Model (CoCM). In this model, a PCP is responsible for conducting initial and ongoing assessment; care planning and follow up in collaboration with a BH care manager (or facilitation and coordination of BH services) and regular caseload review with the psychiatric consultant. Financial support also includes enhanced PCP payment for individually billed, non-care team services (e.g., physician or nurse practitioner visits), addition of codes to allow higher payment levels for extended visits required by the most complex patients, and direct support of a BH consultant or care manager. Please refer to Section 4.03.04 of this response for detailed information on all our VBP programs.

D. Describe how the project will utilize telehealth.

Our long history working with local communities supports the use and expansion of telehealth to improve timely access to quality health care in rural, frontier and Native American communities. By extending the reach of PCP and specialty providers across hundreds miles of frontier desert in Arizona and New Mexico, spanning water barriers between Hawaiian islands and mitigating blizzard conditions in upstate New York, we are closing service delivery gaps. We will leverage our national expertise, best practices and strategic partners to improve access to care for Alaskans. We will collaborate with the Department on its ongoing efforts in the Telehealth Workgroup. We have supported telehealth workgroups, such as the AMA Telehealth Coding Task Force, and developed recommendations for CMS consideration and the National Quality Forum, developing a national quality framework for telehealth. We can bring many telehealth solutions for primary, urgent and BH care that will improve access and reduce the cost.

Project ECHO: The ECHO model is a "hub-and-spoke" knowledge-sharing network, using videoconferencing to link expert-specialist teams at an academic "hub" with PCPs in local "spoke" communities. ECHO creates learning communities for clinicians to develop skills to treat members with complex health conditions. During weekly teleECHO™ clinics, clinicians from spoke sites present patient cases to the specialist teams, discuss new patient care developments and determine treatment. Recognizing the Alaska Native Tribal Health Consortium's work to expand access to care through ECHO, we intend to build on that work. We will identify practices interested in expanding their capacity and provide them with financial, operational, technical and clinical support to serve as ECHO spoke sites throughout Alaska.

Telemental Health (TMH): Through TMH, members can access BH services at a local PCP site or, through *myuhc.com*; members can schedule an appointment with a TMH provider in their home. Average wait times for TMH appointments are about half of typical in-office visits, increasing first-call resolution, and improving follow up, readmission rates and outcomes post-hospitalization. We launched our TMH program in Alaska in 2015. Today, we have five TMH providers, including one MD, three MSWs and one PhD.

Improving clinical outcomes with remote patient telemonitoring (RPM): RPM implements a high-tech/high-touch combination of vital sign telemonitoring and telehealth visits that help providers manage care for members with chronic disease such as diabetes. RPM improves member outcomes by providing medication management, promoting adherence with seven-day and 30-day post-discharge visits and providing virtual clinic visit services to members.

Improving medical management of high-risk pregnancies in rural communities: Recognizing the Alaska perinatal regionalization program's goal of healthy outcomes for mothers and babies, we will collaborate with the All Alaska Pediatric Partnership to combine virtual ultrasound and real-time virtual visit capabilities. Using remote monitoring and telemedicine solutions to manage comorbid conditions, we can reduce preterm birth days for high-risk OB members and their babies in rural communities. Anticipated results include improved clinical outcomes for mom and baby, better prenatal compliance, less preterm births and lower neonatal intensive care unit days.

E. Describe how the project may integrate or align with other programs and reform initiatives established under SB 74 (described in Section 2.01). At a minimum, describe how the project will support the State's implementation of the new federal policy on Tribal Medicaid reimbursement, and will align with behavioral health reform initiative.

Our comprehensive managed care model drives population-specific innovation in alignment with the goals of the State's reform initiatives under SB 74. We are prepared to partner with the Department to support these initiatives.

Tribal Medicaid reimbursement: We are aligned with Alaska's goal to maximize the 100 percent federal match for Medicaid services. We understand how important the 100 percent Federal Medical Assistance Percentage (FMAP) is to the State and the tribes and that the process is administratively burdensome and complex. We already successfully support the complex claims processing requirements associated with IHS and IHS/Tribal provider (I/T) claims for services delivered to Medicaid eligible AI/AN individuals. In New Mexico, where 11.6 percent of our Medicaid members are AI/AN individuals, we have established collaborative partnerships with IHS and tribal governments to implement a variety of initiatives to meet the unique Medicaid claims processing requirements for I/T providers and non-I/T providers. Based upon our experience, we will establish resources, such as a Tribal liaison, to collaborate with the State, tribal governments, I/T and non-I/T providers to implement technical changes, claims processes and training programs to support successful claim submission and the collection of the 100 percent FMAP for services provided by non-I/T providers.

Reform of BH managed system of care: Our MCO model aligns with State reform initiatives to develop a comprehensive and integrated BH program to drive best practices and improve efficacy for individuals with SUD or mental health conditions. We will collaborate with Alaska providers and community organizations to provide comprehensive and integrated care to individuals with complex BH needs. Using our provider tools to support administrative simplification, our Whole Person Care model to meet members' social, medical, BH and functional needs and our social supports specialist to connect with community-based services for housing and employment, our model will advance the goals of the BH reform initiative. While we believe an integrated approach is preferable, we also have substantial experience coordinating BH services with administrative service organizations (ASOs). We have experience in Louisiana and Nebraska before the states carved BH into the MCOs, in Pennsylvania where we share care planning with a separate BH entity or in Michigan where we use data from the BH ASO to drive our clinical knowledge. We have established policies and collaboration methods with ASOs to manage mutual members receiving BH services, thus facilitating coordinated service delivery. As part of our collaboration with the selected Alaska statewide BH Services entity, we will collaborate on crisis system design and resources. We will support any non-

Medicaid funds and services (e.g., Federal MH Block Grant, SAPT or potential funds from SAMHSA to address opioid use/dependence) for our members to access in situations where they are transferring in or out of our catchment areas to services in areas of the State under the ASO administration to provide continuity of care.

Home and community-based services – 1915(i) and 1915(k): Our MCO model fully aligns with the State's initiative for 1915(k) HCBS programs and will support increased federal funding to the State and create capacity for services for additional populations. Our recommendation is consistent with CMS guidance on essential elements for managed LTSS programs. Our approach to coordinating LTSS retains the current benefit structure of each HCBS waiver, but provides the waiver services through our integrated model. We have experience with agency-provider, self-directed models and budget model for individuals qualifying for Community First Choice and supporting states with the added Maintenance of Expenditure requirements of a 1915(k). More than 30 years' experience managing 13 state LTSS programs, under a variety of designs, has proven that integrated benefits provide the greatest potential for improved individual outcomes, while simultaneously meeting the State's objectives.

F. Describe how the project will utilize Alaska's health information infrastructure, including the statewide Health Information Exchange administered by the Alaska eHealth Network.

We can help the Alaska eHealth Network (AeHN) refine health information exchange (HIE) strategy in Alaska, analyze ways to increase value and sustainability, assess and build organizational capacity, and develop a strategic road map to maximize and expedite receipt of federal funding. Subject to agreed-upon terms, we will establish connectivity between AeHN and our CommunityCare care management platform for messaging, data sharing, workflow automation and ADT alerts. Depending upon AeHN capabilities and maturity, we may also enable data sharing between platforms and data marts for information such as continuity of care documents (CCDs), lab results, immunizations and disease registries. We have worked with Medicaid agencies to support deployment of incentives for Meaningful Use (MU) achievement. We partner with Regional Extension Centers (RECs) and Medicaid agencies to promote electronic health record (EHR) use in practices and hospitals. We are on select HIE boards across the country and participate in these exchanges, and are willing to serve in a similar role with AeHN. In Arizona, we helped develop a health information technology (HIT) plan proposed for grant funding. We assisted the Office of the National Coordinator for HIT (ONC) RECs in MU and provider EHR adoption through incentives and low cost EHR tools. We helped create HIE participation agreements that resulted in opt-out privacy laws and launched Health Information Network of Arizona. In Alaska, we can achieve similar goals by working with the Department, the REC and AeHN.

Complementing HIE, our CommunityCare platform enables care plan and health data sharing among the IDT and our care managers that enhances care coordination and quality monitoring. It allows the IDT to collaborate and provide comprehensive, integrated supports to members; view and update the care plan; take appropriate action; monitor member progress toward achieving goals; and improve health outcomes. CommunityCare can share CCDs and integrate with provider-practice management systems through HISP/DIRECT secure messaging. It populates hospital and claims data into a Population Registry and can supply ADT data from AeHN or local hospitals and identify evidence-based gaps in care to the IDT. We have experience in multiple states with HIT and making shared information actionable for health homes and Accountable Care Communities (ACCs). As of January 2017, our health information exchange (HIE) experience spans 21 states, 300 practices, 3,000 PCP sites, and over 800,000 members enrolled ACCs. We also support 800 practices serving 1 million members, with proprietary Population Registry technology.

4.02.04 Program Structure and Methods (20 page maximum)

Offerors must provide a comprehensive narrative that describes the program structure and methodology they intend to employ, and illustrate how the design and methodology will serve to accomplish the work and meet the project's objectives. The proposal must include the following:

We are proposing an MCO model for the CCDP because it is the only model that provides a comprehensive, integrated physical and BH benefit that accommodates inpatient and outpatient care, ancillary services and population health supports. A Prepaid Ambulatory Health Plan (PAHP) is a non-comprehensive prepaid health plan that provides only certain outpatient services, such as dental or outpatient BH, and generally does not provide inpatient services. A Prepaid Inpatient Health Plan (PIHP) provides for inpatient or institutional services, but it is not an efficient model for outpatient and ancillary services. Neither of these models effectively addresses the population health goals delineated in Healthy Alaskans 2020. Only an MCO model has the capacity to reduce costs for the State by reducing inappropriate ER and inpatient utilization while improving care coordination and member outcomes.

A. Service Area:

1) Identify the proposed service area for the model. If the service area could potentially change over time, please explain.

We want to introduce the MCO model through the CCDP in the boroughs of Anchorage and Mat-Su, Fairbanks/North Star and Juneau, because these more populated communities include approximately 64 percent of Alaska's Medicaid population. It will take time to implement the MCO model, working directly with providers and community groups to introduce managed care and meet the State's goals. Selection of these boroughs allows us to meet the CMS access standards for PCPs, educate the maximum number of members simultaneously about the benefits of managed care, and affect the changes in population health the State wants to see.

We want to provide a cost-effective, integrated CCDP model that incorporates physical and BH services, pharmacy, dental, vision and transportation benefits. We will facilitate communication and cooperation between payers, providers, members and the State to accomplish the CCDP goals and objectives. We will work collaboratively with the State, following completion of the CCDP, to expand the scope of our Medicaid model to the remaining 15 percent of the State's enrollees, to realize additional cost savings through increased access and improved health outcomes.

UnitedHealthcare is one of the nation's leading Medicaid managed care plans, and our experience introducing an MCO model into communities and states, where one had not previously existed, has taught us that a strategic launch of the CCDP will be more effective and better received. Through our 35 years of Medicaid/public sector experience providing managed care services to more than 5.9 million low income and medically fragile members in 24 states, we have developed an effective and efficient MCO model that can meet the State's CCDP goals. Additionally, our experience serving more than 121,000 military, Medicare and government employee members in Alaska gives us unique insight into the culture, the landscape, and the challenges to overcome when launching a new health care delivery model.

B. Covered Populations:

1) Identify the Medicaid-eligible populations to be served by the proposed project (e.g., families, Denali KidCare, Medicaid Expansion, long-term care participants, individuals dually eligible for Medicare and Medicaid, etc.).

UnitedHealthcare will serve Medicaid-eligible families, Denali KidCare, Medicaid Expansion, long-term care participants, individuals dually eligible for Medicare and Medicaid, and individuals included in each of these groups' subpopulations. No matter what Alaska's Medicaid

members require, regardless of their diagnoses, age or level of disability, we will be able to offer seamless health care delivery.

2) Identify subpopulations the proposed project will serve, if applicable (e.g., individuals diagnosed with specific conditions or chronic diseases, such as Serious Mental Illness (SMI), Substance Use Disorder (SUD), diabetes, or asthma; homeless; individuals reentering society from the correctional system; etc.).

Our proposed project will serve subpopulations that include members diagnosed with chronic illnesses such as serious mental illness (SMI), substance use disorder (SUD), diabetes, hypertension, obesity or asthma; and those who are homeless or reentering society from the correctional system, are in nursing facilities, mental health hospitals and other institutions. We will serve children and adults with special health care needs, including individuals receiving LTSS, and children and youth under 18 years of age with serious emotional disturbance (SED).

People with chronic medical or BH illnesses, or with LTSS needs, cost Alaska's Medicaid system many times more than the general population. Serving these subpopulations requires deep understanding of their special needs, enhanced networks, substantial investments in information technology and intensive levels of care management support. Providing comprehensive care management to these complex, service intensive and expensive populations will enable the Department to both better serve the neediest members and minimize state spending.

3) If the covered population potentially could change over time, please explain.

While the CCDP could include all of the Alaskan Medicaid populations at contract initiation, the introduction of the MCO model works best when the members and providers have the opportunity to learn and understand the benefits and processes that improve health outcomes and operational efficiencies. Therefore, a strategic launch of a CCDP MCO model, as described previously, allows for better outcomes. Following the completion of the CCDP, the covered population could potentially grow to include additional groups of individuals, such as youth in juvenile justice, individuals transitioning from incarceration back into the community, and children in foster care, as well as individuals with intellectual or developmental disabilities (I/DD). UnitedHealthcare also can help the State meet its Single Healthcare Authority goal by synchronizing all of Alaska's current contracts that serve individual members; active and retired state, municipality and school district employees; Medicare; and our new CCDP Medicaid members.

C. Covered Services:

1) Describe the services that will be provided under the proposed project, including expansion of services in future phases if applicable.

We are proposing a fully integrated MCO model, which includes all of the standard Medicaid benefits under the proposed project, and in future expansion phases. We are uniquely qualified to support Alaska in a transition to a comprehensive MCO, which will incorporate all of the nine elements listed in SB 74. This includes comprehensive primary-care-based management for medical and BH services; disease management; coordination of LTSS; pharmacy, dental, optical and transportation ancillary services; and care coordination, with the assignment of a PCP located in the member's local geographic area.

We have studied the unique Alaska populations and provider environment and we will provide an integrated MCO model that provides the members, providers and the State with seamless, one-stop access to clinical and administrative services. Our MCO model incorporates the guiding principles of improved population health, in alignment with *Healthy Alaskans 2020*, with a focus on quality, access, integrated health promotion and prevention. We integrate physical

and BH services, coordinate access across providers, and deliver culturally and regionally appropriate care in the most appropriate setting. Our MCO clinical model enables us to identify both high and low risk members, incorporate transitional and follow-up care after inpatient treatment, and refer members to the appropriate community and social supports, such as career and education training services, and UM. We work closely with our PCPs to implement a whole-person view that prioritizes an understanding of how the member's physical, BH, functional, social and cultural circumstances are interconnected and addressed to maintain health.

Managed Care Services

We offer comprehensive managed care services that are essential for a coordinated member and provider experience. MCO services, such as care management/care coordination, UM, claims payment, encounter submission, provider contracting and practice transformation, are key to maximizing health outcomes and minimizing costs for the State. Our MCO model also integrates Medicaid covered benefits like dental, vision, transportation, HCBS, pharmacy with medical and BH services. Unique to Alaska, we will bring expertise around tribal health initiatives, care coordination with out-of-state specialties and facilities, and housing and employment navigation.

Our care management and care coordination approach recognizes that many complex factors influence the extent to which the member is motivated or has the capacity to make health decisions. We use an integrated initial health risk assessment (HRA) and an algorithm-based, blended stratification process that identifies individuals at various risk levels. We provide intensity and focus of care coordination interventions that are commensurate with their needs. Our PCMH principles ensure that provider practices are able to address the level of risk and intervention required by individuals with different and fluctuating levels of complexity. We use provider-based peer support specialists that are tasked to support members with mental health (MH) and SUD, including pregnant women, to promote recovery. Through this health benefit, participating members and their family can embark on the road to recovery from MH and SUD symptoms. This benefit can help a member improve his/her overall physical and BH, and it can help to reduce hospitalizations and ER visits related to BH complications. We will assist providers in employing AI/AN peer support specialists with knowledge and insight into these cultures.

In addition to the mandatory Medicaid covered services, we will expand services and resources to support individual's community housing and employment integration goals. Our housing navigator will have extensive local experience and contacts to identify and build partnerships with resources that provide housing and housing support to individuals throughout Alaska. Our employment specialist will have extensive experience with supported employment and will build relationships with employment agencies and employment network providers.

Evidence-Based Guidelines

Evidence-based guidelines developed by experts in their respective fields support our UM approach. Our physician and pharmacy staff span across specialties, rural and urban practice experience, and multiple settings, such as hospitals, clinics and nursing homes. This experience has helped to develop our UM approach using national guidelines, like the SAMSHA guidelines for mental health and substance use, or the American Orthopedic Association for approaches to joint replacement.

Facets Community Strategic Platform (CSP) is our comprehensive, cohesive technology suite that pairs industry-leading Facets software and innovative, internally developed components to meet the unique requirements of the populations we serve. With CSP, we are able to execute an accurate and organized billing and collections system with the ability to track all payments,

payment methods and refunds. Increased understanding and transparency in the claims process not only helps to mitigate these risks, but also offers a platform for continuous improvement within the claims process. This led us to develop the Care Provider Early Warning System (CP-EWS), which uses data collection and analysis to monitor the health of the claims process to provide timely warning when adverse issues threaten, and then elicit the appropriate response. Our state-of-the-art claims platform has been supporting Medicaid populations for 35 years, refining our systems and capabilities to meet and exceed the expectations of our partners.

Our evidence-based approach to provider contracting and practice transformation focuses on improved quality and reduced unnecessary utilization. From experience, we know engaging PCPs in practice transformation requires a culture change, time, business process reengineering and long-range commitment. We also include the voice of providers and consumers in the process by actively engaging our provider and member advisory councils, which we will form in Alaska upon award. We employ and proactively train a diverse network development and provider services workforce that is comfortable working with HCBS providers, FQHCs, BH providers, PCPs, hospital systems and specialty care providers.

INTEGRATED CARE APPROACH

Our comprehensive MCO model allows for the most integrated approach of Medicaid covered benefits, which allows us to holistically understand our members' needs, and make knowledgeable UM decisions and care management interventions. Our MCO model is designed to integrate dental, vision, transportation, HCBS, pharmacy with medical and BH services, and includes a full range of maternity and preventive care services. It also includes unique benefits like housing and employment assistance, which are critical to whole person care and are only made possible through deep partnerships in the community. To meet the needs of our Alaskan members, we will focus on connecting every individual to the benefits of primary care. We will actively promote a meaningful partnership between each of our members and his/her own primary care team of medical, BH and community specialists. Our PCPs will be trained to deliver coordinated, integrated care that meets each member's needs and continually monitor each member to verify the member is achieving his/her goals and experiencing improved health outcomes, based upon the established care plan. We will support Alaska's Perinatal Regionalization program that leads the nation in maternal and child health outcomes as a primary component of our prenatal and post-natal obstetrics services. We also will collaborate with IHS to improve Alaskan Native women and infant birth outcomes. We will work closely with IHS paraprofessional community-health aides (CHAs) to provide sub-regional nurse practitioners and physicians who can lend supervision and support either through telemedicine or over the phone. We will support the CHA enhanced training to include improved predictive processes that recognize and identify at-risk pregnant women and women experiencing early preterm labor or other complications such as infants with low birth weight or requiring admission to the neonatal intensive care unit.

Our tribal health initiatives include unique solutions like supporting Wellbriety circles with our partnership with White Bison. The ***Wellbriety Movement*** follows the Four Laws of Change and the Healing Forest Model to support individuals with alcoholism and SUD. The Circles address the underlying spiritual and cultural issues such as the anger, guilt, shame and fear that contributed to the onset of addictive behaviors, and they foster a culturally relevant approach to sobriety. A Wellbriety Circle is currently active in Fairbanks; we will support the establishment of locations in Anchorage/Mat-Su and Juneau, and they will be open to anyone, whether or not they are our members.

White Bison is an internationally recognized Native American operated training institute and center of excellence, and provides culturally based Wellbriety Movement training for professionals and grassroots activists who work with individuals, families and communities. *White Bison will provide training for us in each of the three boroughs (Anchorage/Mat-Su, Fairbanks/North Star and Juneau) in year one.* The training will educate the community/providers to promote cultural competency for engagement and treatment of Native Americans, Alaska Natives and American Indians through Wellbriety Circles, which are an outgrowth of those trainings. The training will be designed for providers, community leaders, and social services and resources, as well as Alaskan Native tribes and IHS.

Expansion of Services in Future Phases

Following the CCDP, we will collaborate with the Department to expand to cover waiver services for individuals with an intellectual/developmental disability (I/DD), services for justice release and members transitioning from incarceration back into the community. People reentering the community from institutional and correctional settings are especially vulnerable to relapse and recidivism when they fail to access the care that is necessary to facilitate their successful reentry.

D. Eligibility or Enrollment Criteria:

1) Describe any eligibility or enrollment criteria that could have a significant impact on the enrolled population, for example, the definition of medically frail.

Our goal for the CCDP is to provide coverage for all segments of the member populations, as currently enrolled, with no restrictive eligibility or enrollment criteria unless specified by the Department. This allows for one comprehensive, coordinated program for all eligible individuals. We follow written policies and procedures for enrolling all eligible populations and accepting the enrollment of all individuals appearing on State enrollment files. We do not discriminate against individuals based upon health status race, color or national origins, or the need for health care services. We respect and recognize cultural, linguistic, gender, sexual orientation, socioeconomic, and spiritual- and faith-based differences and how they influence an individual's desire and ability to engage in his/her health care decisions.

2) Describe whether the project will require mandatory versus voluntary enrollment.

Our recommendation for efficient execution of the CCDP is selection of UnitedHealthcare as the project's sole MCO. As the sole MCO, we recommend automatic passive enrollment with an opt-out option as allowed by CMS rules (no mandatory enrollment with one MCO). If the Department selects two MCOs, we suggest requiring mandatory enrollment with automatic member assignment to both MCOs, and allowing members the ability to change MCOs within a reasonable time frame following auto-assignment.

We recommend these options because our experience suggests they will lead to a more successful program for the state, the members and providers by:

- Providing the state with a more predictable cost structure

We understand that successful transitions require stakeholder and enrollee education. Through our experience, and with the Department's approval, we will support CCDP understanding and extend the reach of health care services in Alaska by:

- Producing digital and printed educational materials
- Partnering with providers and community-based organizations to provide education and materials
- Leveraging our public website, *uhccommunityplan.com*, to help potential members easily obtain information about benefits and providers

- Improving member outcomes as influenced by consistency of care and provider continuity
- Allowing providers to establish an ongoing health plan relationship — increasing program understanding and building confidence

3) Describe minimum and/or maximum enrollment thresholds, and describe the rationale.

Our minimum enrollment threshold depends upon the final structure of the program. Ideally, we would like to see membership of not less than 42,000, allowing us to leverage economies of scale to maximize efficiencies between providers, but this number is flexible. We do not have a maximum enrollment threshold and we welcome the opportunity for additional discussions with the Department on enrollment thresholds.

E. Care Coordination:

To best serve the needs of Alaskans, we will implement our person-centered, recovery-oriented, holistic ***population health approach*** to care coordination. Through this approach, we risk stratify our entire population of members, and identify and coordinate the delivery of services and supports that match the level of each member's risk through PCP interventions, prevention and chronic disease management interventions and high risk care management.

We provide care coordination to members with emerging and high risk, and provide an intensity and focus of care coordination interventions commensurate with their needs. Our ***Whole Person Care model*** prioritizes an understanding of how the member's physical, behavioral, functional, social and cultural circumstances are interconnected and need to be addressed to maintain health. We engage resources, services and supports to help members meet their needs and achieve their goals and desired outcomes. The core elements of our model include:

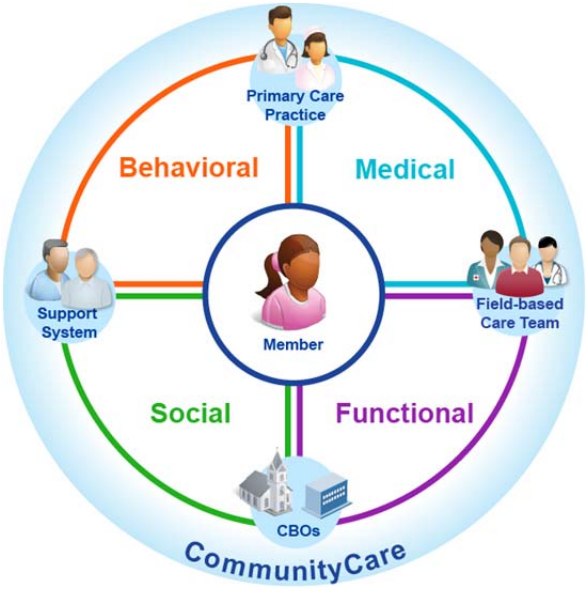

Figure 1. Whole Person Care model. Our integrated approach coordinates care across social, BH, medical and functional needs to achieve our mission of helping people live healthier lives.

Primary care team engagement: Our model promotes a meaningful working partnership with the member and his/her own primary care team of medical, behavioral and community specialists. With every member interaction, we confirm the member has a PCP and is actively engaged with his/her PCP and primary care team. We recognize the importance of supporting the PCP to enhance, coordinate and monitor the member's care. We provide PCPs with data and tools to evaluate each member's risk level and identify the BH and specialty care being delivered. Our model incorporates PCMH principles, confirming that provider practices are capable to address the level of risk and intervention required for individuals with different and fluctuating levels of complexity. We actively focus on building advanced primary care capacity at the provider practice level, including the ability to coordinate member care and deliver integrated physical health, BH and LTSS. We provide distinct supports for practices that help them develop and continually improve their capacity for providing advanced team-based care coordination,

including transformation consultants who work with the practice and technologies that support the practice's ability to deliver person-centered care and population health management.

Focus on social determinants as a significant contribution to an individual's health: Members with high utilization and high costs often face numerous challenges and our experience shows even the best interventions may be ineffective unless we first address their fundamental needs, such as housing. Using the findings from assessments that identify social determinants and a care planning process that incorporates social determinants and tools that identify community resources, we connect members to resources and provide face-to-face and telephonic supports that remove barriers to care so that the member's health care needs become the focus.

Integrated, field-based, team-based approach: Core to our model is direct engagement with high risk and emerging risk members through a care team, comprising an RN and a licensed BH care manager and a CHW. The team collaborates to coordinate, enhance and monitor the member's care using the right expertise and an intensity of engagement that meets the member's primary diagnosis (e.g., the BH care manager leads the effort to coordinate care for a member with primarily BH needs).

Figure 2. Our field-based care team stays actively engaged with members, providing flexible care coordination and targeted interventions to meet each member's unique needs.

Supportive technology: A flexible approach to care coordination allows us to monitor the health of a larger volume of members and customize interventions to each member's needs. CommunityCare, our secure, cloud-based care management system, facilitates the delivery of whole person care coordination by implementing technologies that share the member's care plan and provide the member, his/her support system (with member consent), our field-based care team and other IDT participants with real-time, actionable information and the tools to monitor each member's progress toward achieving his/her goals, ensure he/she is experiencing improved health outcomes and monitor for acute events.

1) Describe the methods that will be used for risk stratification and assigning risk scores, including how members with complex/chronic needs who would benefit from care coordination will be identified. Discuss use and timing of health risk screenings and data analysis, as applicable. Describe how methods will address both new and established members.

We have implemented an identification and risk stratification process that incorporates the most recent science on risk stratification and persistent super-utilizers as well as our experience with how social determinants and BH conditions contribution to overall risk. We assign members with persistent highly complex/chronic needs to the highest risk strata. The Alaska environment presents many unique challenges to the delivery of care but, through their identification and stratification process, we can match appropriate resource to member needs, and even the most complex medical and social needs can be successfully addressed.

As presented in the figure and the table that follows, we have operationalized a systematic methodology for population health management that mobilizes data to understand the medical, behavioral, social and financial circumstances; characteristics; needs; level of current and potential health risk of each member across the health care continuum. This methodology helps us quickly identify new members who may benefit from engagement in care coordination, and monitor the ongoing health status of our existing membership to identify members with changing needs that may require engagement in care coordination.

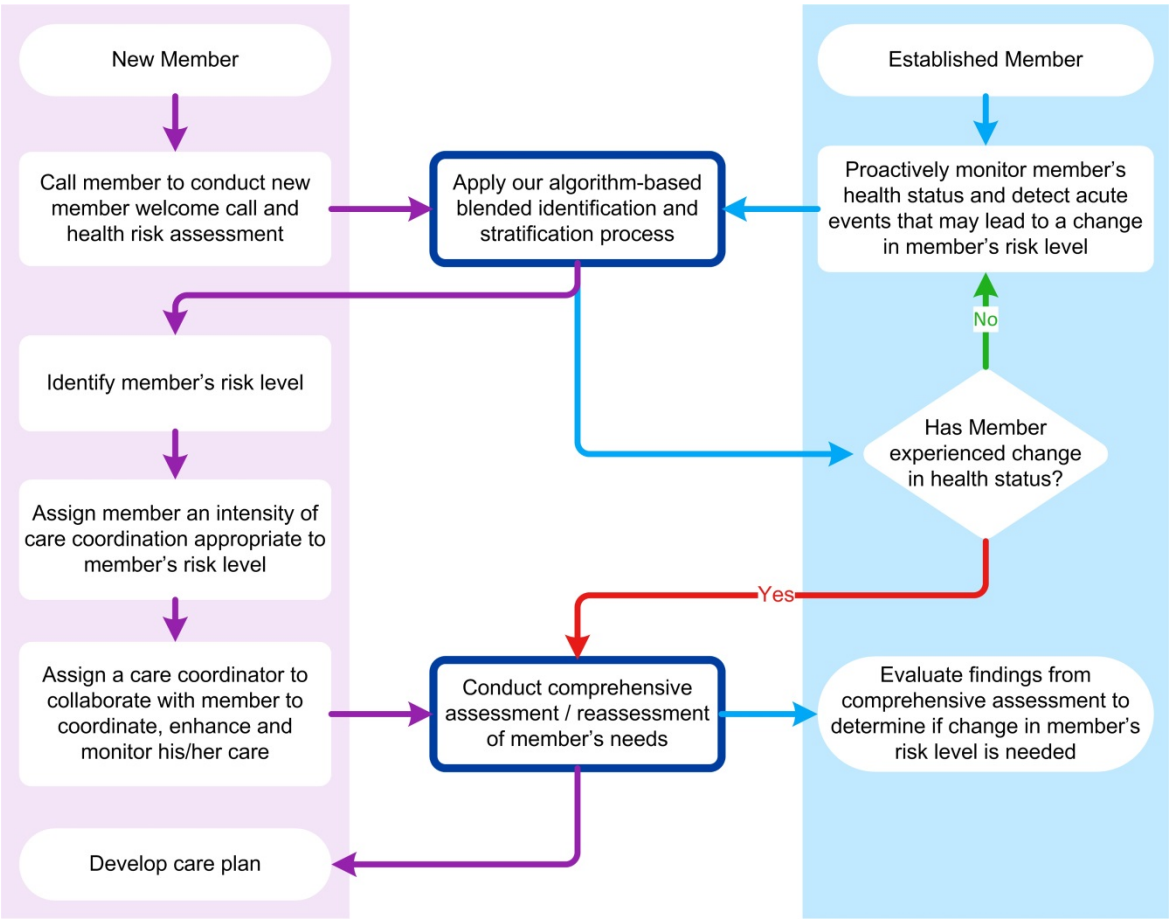

Figure 3. Identification Process for New and Established Members. We incorporate integrated initial and comprehensive assessments, analysis of internal and external data, and algorithm-based blended identification and stratification process to understand each member's level of current and potential health risk. Our process identifies members that can benefit from care coordination and identifies the intensity and focus of their needs.

The following table presents our methods to identify and risk stratify new and established members for engagement in care coordination.

Methods to Identify and Risk Stratify Members for Engagement in Care Coordination
New Member Assessment at Enrollment via a Welcome Call within 60 days of Enrollment
Our *Advocate4Me* member services team conducts new member welcome calls during which they complete a HRA within 60 days. Our HRA evaluates the member's overall health and wellness and identifies social, behavioral, medical and functional needs; current PCP and provider relationships; active treatment plans; overutilization and underutilization of services; and barriers to care that could affect the member's ability to access care and improve his/her health outcomes. Our HRA tools are evidence-based and include screening questions for depression and substance use. Our age-specific HRA for children/youth also screens for childhood trauma, which is known to be a predictor of risk. The HRA provides an initial risk stratification and individuals deemed high risk through the HRA process have additional outreach to assess care coordination needs.
Algorithm-based Blended Identification and Stratification Process – Monthly
We evaluate all members, new and established, monthly via our evidence-based stratification process. We perform this process on every member, every month. We integrate medical, behavioral and pharmacy claims; lab test results and analyze gender, age, other demographic variables and social risks (e.g., homelessness), future inpatient risk, prior year total cost of care spending, acute inpatient admissions, ER visits and persistency score. Our analysis delivers a prospective risk assessment for each member and identifies the

Methods to Identify and Risk Stratify Members for Engagement in Care Coordination
clinical and utilization events affecting their health risk. Our analysis also identifies members with complex/chronic needs. We identify members who can benefit from care coordination using the following risk stratification criteria: ▪ ***High risk:*** Members who have both the highest total cost of care and likelihood of persistent future costs. These members are likely to be in the top 2 percent of health care costs in the next 12 months and are likely to continue to experience high utilization from year to year. Individuals in this risk group often have more chronic conditions, higher prevalence of BH diagnosis and complicating social needs. ▪ ***Emerging risk:*** Members with impactable opportunities who, without intervention, will likely be in the top 15 percent of health care costs in the next 12 months. They have risk factors, such as multiple medications, a BH medication with no BH provider and the presence of social determinants.
Proactive, Continuous Monitoring for Established Members - Daily
In addition to our identification and stratification process, we proactively monitor each member's health status and detect acute events that may lead to an escalation of his/her utilization. Our clinical systems are able to alert when a member has experienced an acute event, such as a hospitalization, ER visit or have gaps in care. We evaluate inpatient admissions for the likelihood of readmission to ensure appropriate care coordination support is provided. When alerted to a change in health status, the care team will implement timely, targeted interventions to prevent an escalation of the member's conditions.
Evaluation of Maternity Risk
Due to the importance of timeliness for outreach for pregnant members, we have a unique process that addresses pregnancy risk. Immediately upon notification of pregnancy through enrollment files, OB risk assessment forms, claims or member report, individuals are assigned their first level of risk based upon their engagement with an obstetric provider. We further evaluate maternity risk through telephonic outreach to the member using a Maternal Health Risk Assessment to understand care coordination needs during pregnancy. The risk assessment screens for prior preterm birth, which may suggest a need for 17-P injections or substance use, social needs or other conditions for the care team to address.

2) Describe the proposed process for conducting comprehensive assessments of members with complex/chronic conditions, including the qualifications of the persons who would conduct the assessments and the areas (domains) to be assessed.

Upon completion of the health risk screening, we assign care coordination and a care team that performs an assessment appropriate to the level of risk and team member capabilities. For example, CHWs complete an Access to Care assessment to explore social barriers and the member's choice and access to a PCP. The care manager performs both a comprehensive and functional assessment to identify the services and supports needed for a member with LTSS needs. Care team assignment also considers cultural or linguistic needs of the member. Target timeline for completion of a comprehensive assessment is within 30 days after the identification of a member with complex/chronic conditions.

Assessment	Process	Qualifications
Integrated Comprehensive	Telephonic or face to face	Licensed clinical social worker or licensed nurse
LTSS Comprehensive Functional assessment	Face to face	Licensed clinical social worker or licensed nurse
Access to Care assessment	Telephonic or face to face	Community health worker

COMPREHENSIVE ASSESSMENT DOMAINS TO BE ASSESSED

Our comprehensive assessment identifies the member's needs, goals and desired outcomes in the following four domains:

- ***Medical/behavioral*** identifies issues related to the individual's physical, mental or emotional health issues. Examples include member's perceived health status; chronic,

complex or comorbid medical and BH conditions/concerns; SUD; and current treatments and medications.

- ***Social determinants*** identifies issues related to the individual's social determinants of health, such as financial resources, employment status, living situation, caregiver support, risks related to housing and food security, community and personal safety, awareness of available community resources, transportation concerns and health literacy.
- ***Functional*** identifies issues related to the individual's ability to maximize independence and live in the setting of his/her choice. Some examples include the individual's ability to perform activities of daily living (ADLs) and instrumental ADLs (IADLs); his/her ability to make decisions; available caregiver and natural supports; and his/her desire or ability to self-direct services.
- ***Quality of life*** identifies items of importance to the individual's quality of life; what he/she needs to meet personal goals, risks he/she is comfortable with, and what makes him/her feel safe and free from abuse and neglect. Examples include where and with whom to live; daily activities the individual would like to do; and important relationships.

Comprehensive Assessment

We have developed age-appropriate comprehensive assessments, including our adult assessment for members 18 years or older and our pediatric assessment for members under 18 years.

Our comprehensive assessment is essential to holistically identifying the individual's desired goals, outcomes, strengths, preferences, needs for support, available natural supports and the individual's medical, BH, functional, social, cultural and health literacy circumstances. It identifies high-risk conditions, family history, family supports, current and past medical history, personal behaviors, social history and environmental risk factors. It screens for utilization, caregiver support, self-management, medication management, environmental concerns, health equity, educational needs, healthy behaviors, health literacy, disaster planning, in-home support service needs, medical and BH service needs, specialized therapy needs, concerns related to social and safety needs, and awareness of available community resources. The assessment determines the need for evidence-based, condition-specific screenings (e.g., diabetes) and BH assessments (e.g., PHQ-9) to address BH needs identified through data analysis or the HRA.

Functional Assessment

During the face-to-face comprehensive assessment, the care manager may use our functional assessment tool to determine the member's assistance needed to perform key tasks. The assessment evaluates the member's ability to perform ADLs and IADLs, available natural supports, durable medical equipment (DME) needs, any special dietary requirements and other information, such as access to equipment needed to do laundry, whether the individual has home-delivered meals, and indications he/she may be feeling down or depressed, has trouble sleeping or has short-term memory impairments. The care manager inquires about and observes the member's ability to perform ADLs and IADLs and to perform functions, and documents what the member says he/she can do with the care manager's visual confirmation.

Access to Care Assessment

The CHW uses the Access to Care assessment to understand the member's barriers to accessing care. The member's responses help us develop the member's care plan. We ask the member questions, such as: During the past year were you ever unable to pay for or had to do without food, medicine, transportation, electricity, heating or housing? Do you know who your PCP is? Do you have issues obtaining transportation to appointments or getting your

prescriptions filled? Do you have safety concerns? These questions prompt the interventions and action plan to address identified needs.

3) Describe the proposed process for using assessment findings and other relevant data to develop care plans for members with complex/chronic needs. Discuss whether and when members would be aligned with an Interdisciplinary Team (IDT) and the composition of such teams.

The goal of care coordination is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. The care team uses assessment findings and any other information relevant to member health and well-being as a core component of care coordination and care plan development. Our field-based care team collaborates with the member, the PCP and other providers to develop a member-centric plan assuring that it addresses the unique individual needs and barriers, is culturally appropriate and can affect care and health outcomes.

The care manager has the overall responsibility to help create, document and review the care plan in CommunityCare, our care management platform. The care manager will have the qualifications to oversee the plan to address all clinical, functional and social issues. The developed care plan is not static, but is continually updated based upon the changing needs or as goals are achieved. As an extension to the comprehensive assessment process and as indicated by the intensity of the member's need, the care manager, supported by the care team, performs the care planning activities presented in the following figure.

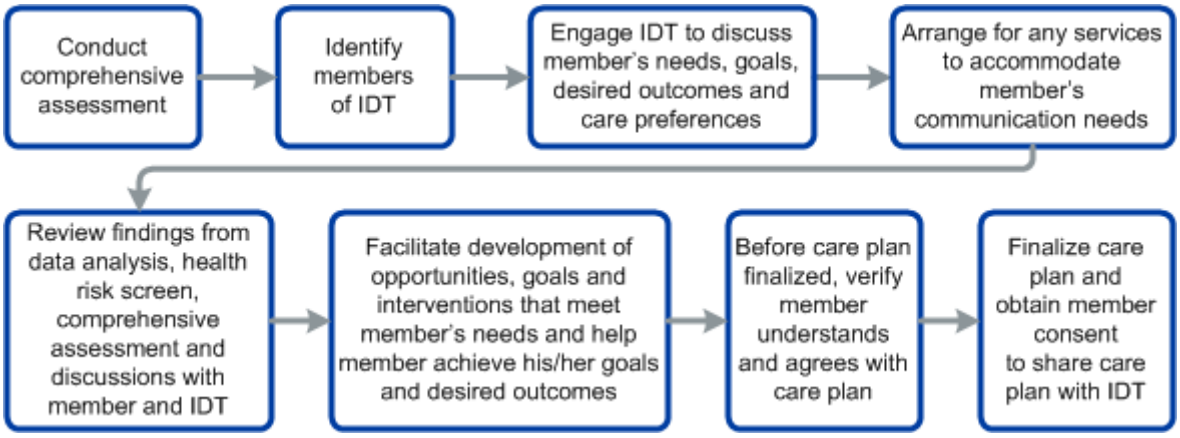

Figure 4. Care Planning Process. Using our care planning process, the care manager will facilitate the development of care plan that includes the social, BH, medical and functional services and supports that meet the member's needs and preferences, and help the member achieve his/her goals and desired outcomes.

The assessment process triggers a suggested problem list or opportunities, and suggests associated goals and interventions based upon an understanding of the member's risk and interventions that can affect that risk. For example, for an individual who reports cigarette smoking, it may suggest tobacco cessation as a goal and discussing tobacco cessation options with PCP as an intervention. We use evidence-based care management practices that include motivational interviewing to help the member to restate and prioritize his/her own identified opportunities, goals and interventions. This confirms the care plan remains member-centric and engaged members are more successful in completing the steps necessary to meet their goals.

ALIGNING WITH THE IDT

All members receiving care coordination are aligned with an IDT. At a minimum, the IDT comprises the member, our field-based care team, the member's PCP and can include anyone selected by the member. The care manager works with the member to identify IDT participants during the comprehensive assessment and gains his/her approval to add individuals to the IDT. The care manager also ensures and oversees accountability of IDT members for each of the care plan problems and goals. We empower members to actively make decisions/choices about their care and services with the support of their chosen IDT.

Incorporating Condition-Specific Education into Care Planning

We have aligned our condition-specific interventions with the health priorities of *Healthy Alaskans 2020* (e.g., increase the percentage of adults who currently do not smoke cigarettes to 83 percent by 2020) and improve the health and health outcomes of Alaskans. Our programs include smoking cessation, obesity, depression and SUD. We provide health education materials for these conditions that help members manage them, such as recommended routine appointment frequency, necessary testing, monitoring, self-care, medication adherence, the importance of keeping lab and medical appointments; and how to interact with their physician and other providers. In addition, for members engaged in care coordination, the care manager will incorporate condition-specific health education and prevention into the care plan process. Some examples of condition-specific interventions for members engaged in care coordination include:

Maternity management: Our Healthy First Steps (HFS) maternity management program promotes healthy birth outcomes for pregnant members, especially those with high-risk pregnancies. HFS enhances practitioner-patient relationships and care plan compliance by emphasizing activities and treatments that can help prevent pregnancy related complications, using cost-effective and patient-involvement strategies, such as:

- ***Text4baby:*** A free service for pregnant women and new parents that delivers tips and support via text messages during pregnancy and baby's first year. Topics include exercise, fitness and nutrition; labor and delivery; car seat safety; and breastfeeding. Women who sign up for the program receive texts two to three times a week. Messages are customized to specific milestones, such as baby's due date or birth date.
- ***Baby Blocks:*** A 24-month program that rewards and encourages pregnant women and new mothers to attend prenatal, postpartum and well-baby appointments. With an engaging web application and attractive rewards, Baby Blocks reminds and rewards members for attending appointments during their pregnancy and baby's first 15 months. The program uses mobile-optimized engagement tools, including an easy enrollment process, appointment reminders and health tips.

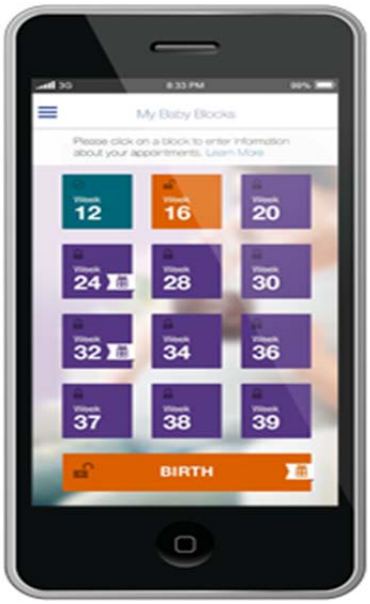

Figure 5. Baby Blocks reminds and rewards members for attending appointments during their pregnancy and into the first 15 months of their baby's life.

Depression: Our depression program helps members establish and maintain a therapeutic alliance, increase functionality and positive family and supportive care interactions, improve adherence to treatment plans and medication regimens, and identify early symptoms to take

action. Care managers work to establish trust, which promotes open dialogue; allows the member to articulate his/her feelings about his/her treatment regimen; allows the care manager to promote sustained, continuous relationships between the member and his/her providers; and promotes collaboration to implement interventions that maximize the member's level of functioning and quality of life. In addition to proactive monitoring using the PHQ-9, interventions may include implementing a safety/no self-harm contract; assessing medications; and education on the disease process, symptoms and treatments. Through *myuhc.com*, our health and wellness library provides resources for members with depression, such as self-paced cognitive behavioral therapy for depression.

Substance use disorder: To assist emerging or high-risk members with SUD on their road to recovery, we provide an array of care coordination activities, services and supports. The care manager will determine where the member is on the continuum of readiness for change and collaborates with the member and the IDT to:

- Engage peer supports that complement BH treatment and help create a safe and effective environment for members as they transition across levels of care. Peers participate in the member's care planning process, help develop a wellness recovery action plan (WRAP) and psychiatric advance directive, and help members identify ways to live a healthy and productive life, which is the essence of the recovery philosophy.
- Engage SUD recovery coaches to help members and their support systems in a variety of ways, such as creating a change plan, linking them to resources for harm reduction, detox, treatment, family support and education or local support groups, such as a Wellbriety Circle facilitated by White Bison.

SERVICE PLAN

For members receiving HCBS, the care manager will collaborate with the member to develop a service plan, which is a component of the care plan that documents all paid and unpaid services to be provided to the member. Our service plan process promotes member empowerment and independence and confirms the services and supports identified in the service plan support the member in the safest, least restrictive environment of his/her choice and help each member achieve his/her desired goals and outcomes. To identify and authorize services in the service plan, the care manager evaluates the functional assessment and uses relevant medical, BH and HCBS decision support tools and criteria. He/she collaborates with his/her supervisor to verify the appropriateness of the services in the service plan.

4) Describe the proposed process for monitoring implementation of care plans and for updating care plans.

The care manager has the overall responsibility to monitor member status, manage the care plan, assure periodic review and update, and verify IDT members are accountable for addressing the appropriate member goal assigned. As presented in the figure, through valuable discussions with the enrollee, referrals from IDT participants and using CommunityCare, the care manager proactively and continuously monitors each member's health status and progress toward achieving his/her goals so they can respond to data indicating a need and take action to meet the need and prevent an escalation of the member's utilization. It detects acute events that may require a specific intervention, a comprehensive reassessment, a care plan update or a change in the care-management risk level.

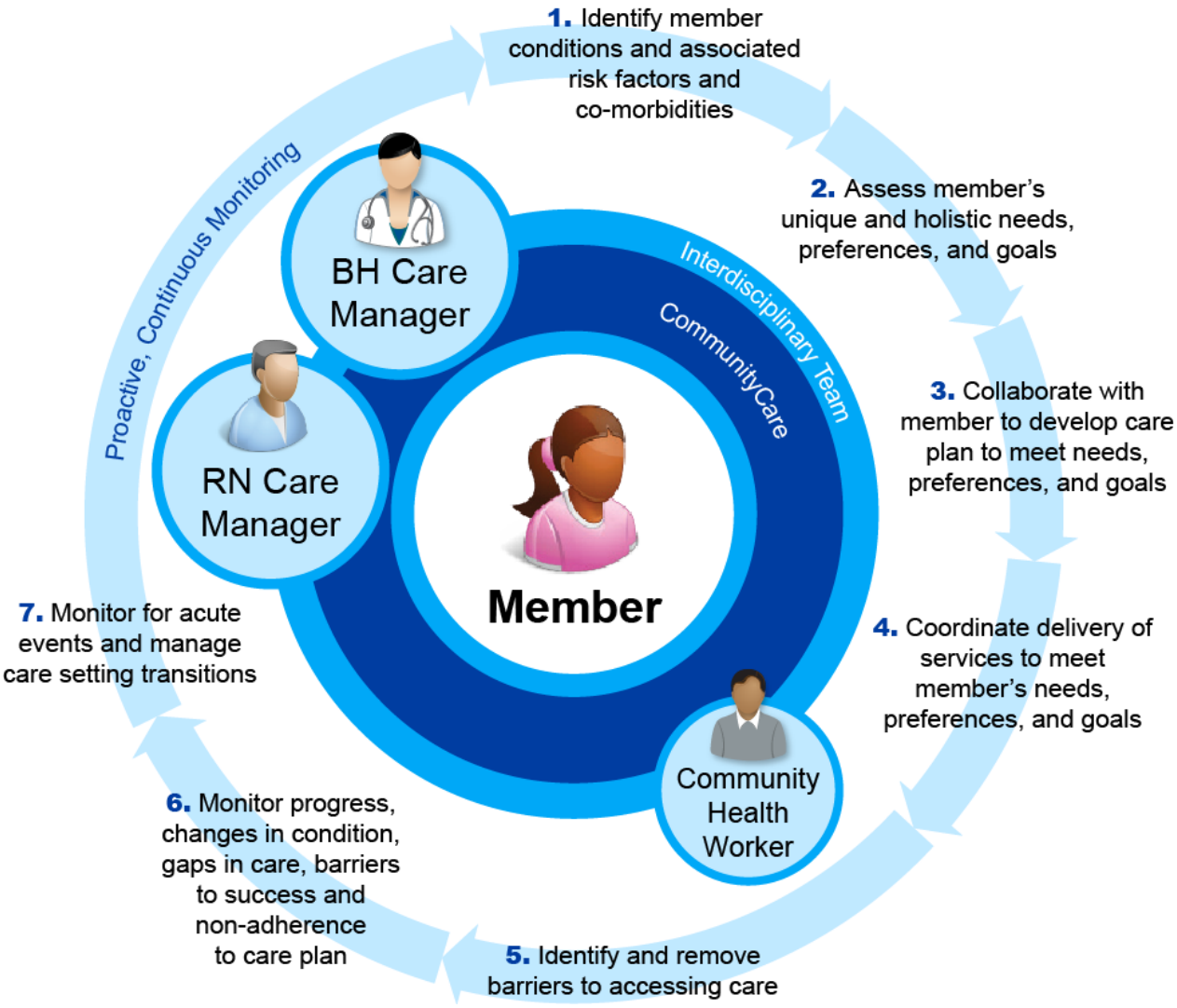

Figure 6. Care Coordination for Members with Emerging and High Risk. The goal of care coordination is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. Our field-based care teams coordinate care for individuals who will benefit from care coordination. The team collaborates to implement services and supports using the right expertise and an intensity of engagement that meets the member's needs.

Using CommunityCare to Monitor the Member's Health Status

CommunityCare, our electronic care management platform, allows the care manager and IDT to document and report the member's progress and implementation of his/her care plan and make sure the care plan continues to meet the member's needs. The member, PCP and other providers can also view and update the member's clinical progress. CommunityCare supports the efforts of the care manager and the IDT to proactively monitor each member's health status and progress toward achieving his/her goals so they can respond to data indicating a need, take action to meet the need and prevent an escalation of the member's utilization. It detects acute events that may require a specific intervention, a comprehensive reassessment, a

Using CommunityCare, providers can collaborate with our care management teams to coordinate, manage and enhance the care provided to our members. They have access to the same information and tools as the care manager, such as gaps in care alerts or viewing and updating the status of goals in the member's care plan.

care plan update or a change in the care-coordination risk level. The care manager uses CommunityCare to:

- Monitor the member's progress toward achieving the goals in his/her care plan. Members making progress toward achieving the goals in their care plan should experience improved clinical outcomes.
- Respond to alerts to changes in the member's health status by continuously integrating claims/utilization data and lab and predictive modeling results. Changes in the member's health status may indicate the member is not receiving the services in his/her care plan or that the services in the care plan are not meeting the member's needs.
- Monitor the member's adherence to his/her care plan. Indications that a member is adhering to his/her care plan is an indication that the services in the care plan are being delivered and that they are meeting the member's needs, which should lead to improved clinical outcomes. (e.g., a member with asthma not filling prescriptions for a rescue inhaler).
- Act on data presented in an actionable way, such as the results of an HbA1c test that indicates poorly controlled blood sugar levels, a member with asthma not filling a prescription for a rescue inhaler, or a first fill of insulin identifying a member with newly diagnosed diabetes.
- Respond to ADT alerts from the Alaska HIE or direct hospital feeds, such as a member who may be experiencing an inpatient admission or an ER visit.
- Respond to information that identifies gaps in care using CommunityCare's planning tools to close the care gaps and confirm their completion.

Updating the Care Plan due to a Significant Change in Status

As presented in the figure, through valuable discussions with the member, referrals from IDT members and using CommunityCare, the care manager proactively monitors each member for indications that the member's health status has changed or the member has experienced or is at risk for experiencing an acute event, such as a hospitalization. When the care manager sees these indications, he/she will engage the member and his/her IDT to implement timely, targeted interventions to meet his/her needs, collaboratively reassess his/her needs using the comprehensive assessment and update the member's care plan, as needed.

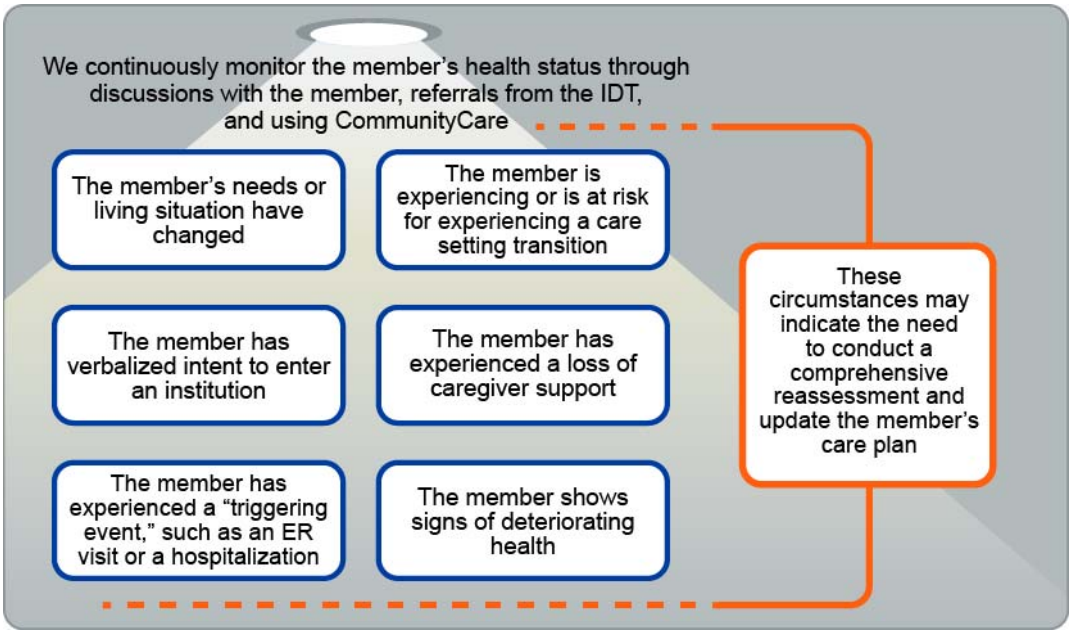

Figure 7. Circumstances that Would Trigger a Care Plan Update. The care manager and IDT proactively monitor each member for indications that the member's health status has changed or the member has experienced, or is at risk for experiencing, an acute event. When the care manager sees these indications, he/she will engage the member to implement timely, targeted interventions to meet the member's needs, collaboratively reassess his/her needs and update the member's care plan, as needed.

5) Describe how clinical data will be shared within the IDT and how Alaska's health information infrastructure will be utilized, including the Health Information Exchange (HIE) administered by the Alaska eHealth Network.

Central to the success of our Whole Person Care model is our ability to share data about our members among IDT participants. Near-real-time data sharing allows the care manager and the IDT to proactively monitor each member's health status and progress toward achieving his/her goals so they can respond to data indicating a need and take action to meet the need and prevent an escalation of the member's utilization. Through data exchange, the care team can also detect acute events that may require a specific intervention, a comprehensive reassessment, a care plan update or engagement in care coordination. CommunityCare provides a mechanism to share member data among IDT participants and provide the capability to monitor each member's health status.

We successfully exchange data with our state partners in each of the 24 state Medicaid programs we serve. We have developed a comprehensive electronic data interchange (EDI) framework and related standards that enables us to exchange electronic health information with the State's clinical information systems, the Alaska HIE, provider practice management systems and hospitals. We flexibly exchange data in standard formats, custom formats, and standard and nonstandard interfaces. We support DIRECT, HL7/CCDAs; ADT; LOINC; and all major HIPAA X12 formats. We are familiar with and handle confidential information in compliance with HITECH and HIPAA requirements.

Using Alaska's Health Information Infrastructure

We look forward to supporting the efforts of the AeHN to promote the use of EHRs and provide Alaskans with a secure health information exchange. We have considerable experience in the adoption of EHRs, HIE and Meaningful Use (MU) that we will bring to Alaska. We also have significant experience supporting specific AeHN initiatives, such as leveraging CMS HITECH funding to expand the capabilities of the Alaska HIE, engaging providers to implement HIE technologies and supporting the hospital-led Emergency Department Information Exchange

(EDIE) initiative. For example, in Washington we have contracted with Collective Medical Technologies to operate a real-time interface between their EDIE notification system and CommunityCare. If a health home patient seeks care in different ERs — indicating possible fraud, waste or abuse — the EDIE system alerts the hospital and health home IDT to possible misuse and enables emergency clinicians to intervene at the point of care.

While working with other states to operationalize the functionality of HIE, we have seen tremendous benefits, which we would also expect to see through the Alaska HIE, such as:

- Providers and UnitedHealthcare staff have the ability to communicate electronically and exchange information/documents with minimal delay.
- Secure electronic notifications of ADT data are sent to participating practices and transitional care managers. ADT data allows us to understand when members are experiencing a change in care status and conduct appropriate interventions, such as reconnecting the member with his/her PCMH and identifying and implementing changes in the member's care plan.
- Identification of members who have overutilization of services, such as multiple inpatient admissions or ER visits within a specific time frame. This information enables our case managers to reach out to members to address the root causes of the overutilization.
- Reduce duplication of effort by enabling the IDT to access a single repository for member contact information, condition list, medications, service dates and outcomes, history, provider visits, diagnoses, issues, progress notes and case conference notes, lab results, gaps in care and medication adherence.

Sharing Data Among the Members of the IDT

Care manager engagement: In alignment with the member's preferences, the care manager will engage the IDT, including the member's PCP and other providers in regularly scheduled and ad hoc IDT meetings using face-to-face, telephone or technology (e.g., web-based) meetings. For example, during care planning the care manager will share the member's needs, goals and preferences for care delivery and collaborate with the IDT to discuss the interventions, services and supports the team recommends for inclusion in the care plan.

Sharing data through CommunityCare: CommunityCare promotes collaboration among IDT participants to coordinate, enhance and monitor the member's care by providing a mechanism to share the member's care plan and all of his/her health data. The IDT has access to the same information and tools (e.g., assessments) as our care manager. It allows the IDT to collaborate to verify we provide comprehensive, integrated supports to members; view and update the care plan; view actionable information and take appropriate action; monitor member progress toward achieving goals; and validate members' experience improved health outcomes.

Sharing data through our Link provider portal: Our secure, cloud-based *Link* provider portal is integrated with our critical systems and gives providers access to critical and timely information through a single source — facilitating better and more responsive care. Once a provider has completed portal registration, *Link* gives him/her electronic, real-time access to key applications and websites where the provider can view his/her panel roster, obtain State documents, review comprehensive plan information, determine member eligibility, submit claims, check the status of claims, submit and monitor prior authorizations, and view member assessments and care plans.

4.03.04 Program Structure and Methods (10 page maximum for additional information)

F. Provider Payment Model: Describe how contracted providers will be paid, and how value-based payments will be incorporated. If a phase-in approach is proposed, describe that approach. Also specify:

We are committed to implementing value-based payments (VBPs) that reward providers who deliver high-quality, cost-effective care to our Alaska members. As shown in the figure, we have developed a modular suite of VBP models that we can leverage with Alaska providers based upon their risk readiness and other criteria. Our modular suite of VBPs enables us to customize our approach with providers across all stages of the risk continuum and support them as they become more accountable for cost, quality and experience outcomes.

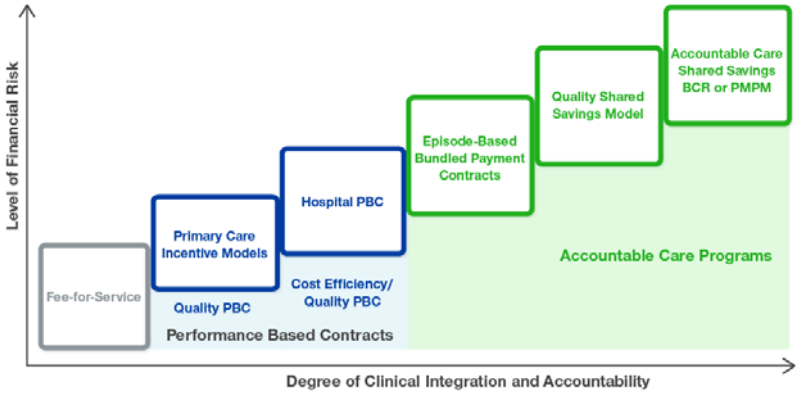

Figure 8. Our modular suite of financial and performance-based provider incentive models.

Our phased approach and vision for Alaska and the CCDP program is to introduce our primary care incentive and Accountable Care Community (ACC) models (described in our response to Subsection 4 of this Section 4.03.04 F), then move providers toward more advanced models. We have successfully implemented similar Medicaid incentive programs and realized improved outcomes in 21 other states. We recently published a value-based care report that analyzed data from our experience with VBPs and documented areas where we have seen improvements in quality. For example, the report finds that we have seen a 10 percent higher rate of colorectal screening among Medicaid providers in VBP arrangements versus non-VBP arrangements. Additionally, across our Medicaid providers in VBP arrangements, we see a 5 percent higher rate of well-child visits in the first 15 months of life compared to their peers in non-VBP arrangements. One in every five UnitedHealthcare Medicaid members nationwide receives care from a physician participating in a VBP.

Upon entry into new markets, we collaborate with primary care practices and health systems around focused areas that are consistent with the state agency's goals and federal health home and population-health management initiatives. These areas include improved member health outcomes; decreased inappropriate use of services; decreased health risk factors among the populations the providers and provider groups serve; and improved access to care. Our planned approach will create incentives and align providers to focus on achieving quality improvements that are important to the state agency and to the CCDP membership. It also will allow providers to establish clinical integration and care management best practices.

As our experience has shown, creating a strong, foundational infrastructure and focusing on aligned incentives, positions our network providers to move into higher tiers of performance incentive models in future years by helping each group evolve toward a higher degree of clinical and financial risk readiness. In this manner, we truly meet providers where they are on the path to performance improvement and create an environment in which they will be able to establish the necessary infrastructure to be successful in future shared savings and shared risk reimbursement models.

1) Anticipated share of services that will be sub-capitated. Specify which service categories (e.g., primary care doctor's office visits) and provider type (e.g., primary care providers only).

We do not anticipate implementing sub-capitation arrangements with Alaska providers in the initial CCDP program contract years. However, in subsequent contract terms, we will pursue sub-capitation arrangements for key services (e.g., delegated care management and service delivery) with mature provider types (e.g., PCPs, HCBS providers and more) who are clinically, operationally and financially ready to drive success in this model. As our experience in other Medicaid markets has shown, sub-capitated arrangements are only successful once a provider has demonstrated strong population health management and quality improvement capabilities through our more introductory VBP incentive models.

2) Anticipated share of services that will be paid for using an alternative payment method such as pay-for-performance or bundled payment methods. Specify which service categories (e.g., primary care doctor's office visits) and provider type (e.g., primary care providers only).

Our goal is to work with Alaska PCPs, FQHCs and multi-specialty provider practices that are rendering primary care to members, as these providers are best positioned to drive member care and facilitate integrated physical, behavioral and community services. These providers will serve as the initial point of contact for CCDP members and play a vital role in our system by improving health care delivery in four critical areas — access, coordination, continuity and prevention. They are responsible for providing primary care services to members, making recommendations/referrals for specialty and ancillary care outside their practice (e.g., hospitals, specialists, BH providers) and coordinating with other care providers for services delivered to our members.

Though we currently do not have specific Alaska provider data and cannot project the anticipated share of services that will paid for using alternative payment methods, we have formed a strategy for implementing VBPs with selected Alaska providers. Our standard approach to VBP provider selection is to work closely with providers and conduct comprehensive quantitative and qualitative analyses to determine which program they are best suited for across the reimbursement risk and clinical integration continuum.

In the first year of the CCDP contract, we will implement our primary care incentive model, collaborative care model and accountable care community model with PCPs and multi-specialty providers who have the highest degree of clinical readiness for these programs and who serve the majority of our members in our targeted Alaska boroughs. These programs focus on incenting providers to improve the quality of care our members receive, as well as provide funding for engaging in clinical integration activities, such as: improving access to care, improving high-risk patient care, reducing avoidable admissions, reducing non-emergent ER visits, improving quality and coding accuracy, and improving growth and satisfaction.

As we move forward into subsequent CCDP contract years, we will work with these providers using our proven provider assessment, support and transformation consulting expertise to help providers mature their VBP operational and financial readiness so we can move them into our more advanced VBP models (e.g., our Quality Shared Savings or Accountable Care Shared Savings models).

3) Proposed quality of care metrics for measuring population health at a plan and provider level. Describe how the data for these metrics will be collected and calculated.

Each program in our VBP portfolio includes a set of quality measures and metrics that will comply and align with applicable *Healthy Alaska 2020* quality-related indicator targets. Regardless of which VBP model a provider participates in, the provider will drive improvement in Alaska's critical health measures. Examples of the quality of care metrics we are proposing to

use in our Alaska VBP models, which will be adjusted to meet specific practice characteristics include, but are not limited to:

- Adolescent well-child visits
- Comprehensive diabetes care: HbA1c testing
- Follow ups after hospitalization for mental illness
- Comprehensive diabetes care: eye exam
- Childhood immunization status
- Timeliness of prenatal care
- Frequency of postpartum care

Described in our response to Subsection 4 of this Section 4.03.04 F, we have developed primary care incentive models that provide participating practices the opportunity to earn bonus incentives/payouts for improved performance in these quality measures. Our more advanced VBP models also focus on quality performance as a key objective while providing additional incentives for achieving savings accrued against total cost of care. In these more advanced models, performance against a suite of quality measures aligned with state metrics determines the distribution of shared savings that providers may earn. In addition, our VBP models are nimble enough that we are able to adjust both the risk and metrics as necessary to meet the State's quality goals, as well as our provider support approach.

Quality Metric Data Collection, Calculation and Usage

We collect quality metric data from a variety of sources — including provider self-reported data, claims, electronic health records from provider offices, supplemental records (e.g., immunization registry), audits and state encounter records — which we upload to our MedCapture NCQA-certified HEDIS software and use to analyze against selected HEDIS measure specifications. For example, we employ an NCQA-certified HEDIS vendor who contacts providers and collects medical records, which are abstracted to obtain the medical information required by the HEDIS measure specifications (e.g., gender, age, eligibility, CPT and diagnosis codes, date of service and provider of service).

Once we have collected and calculated measures, our data analytics and health care economics team uses this data in MedCapture, as well as our other robust analytical and data warehouse tools and applications (e.g., CommunityCare, SMART, Impact Pro™), to conduct monthly and quarterly aggregate and provider/member level performance reporting based upon quality and targeted criteria. We then collaborate directly with participating provider practices to develop a joint work plan targeting specific quality metrics and efficiency goals.

Our clinical practice consultants (CPCs) and transformation consultants, typically RNs with process improvement training (Certified Professional in Healthcare Quality [CPHQ] or Six Sigma), are equipped to share our compiled data in various formats, discuss member level detail with practices, help provider build capacities and mature their clinical practice model. The primary role of CPCs is to improve clinical outcomes and support PCPs and specialists in demonstrating high performance on critical care measures. CPCs also provide education on HEDIS measures, coding requirements and work closely with our provider advocates to supplement clinical discussions with operational information and to introduce new and innovative programs for members and providers. Our transformation consultants meet with practices regularly and review goals, data, quality outcomes and technology training needs to verify provider staff members use the tools and the data to effectively track outcomes.

Overall, we give providers a picture of their progress in improving preventive health for their entire panel, as well as the corresponding member level detail. We also give providers access to clinical operations enabling tools such as our web-based Population Registry (Registry). The Registry offers a population view that offers a high-level perspective on trends and utilization and a patient view that provides a member's three-year clinical history showing pharmacy, lab results, outpatient visits, hospitalizations and ER use. With assistance from our staff, providers are able to make use of this data, to target efforts to close gaps in care, promote appropriate service utilization and improve member outcomes. For example, the Registry screenshot shown here displays the questions and workflow available within the Care Transitions component, tracking post-ER visit follow-up activities at a patient-level. Our transformation consultant trains the provider practice and care team on the use of our Registry, as well as monitor and report to practices on activities performed in the Registry, along with utilization trends and quality measure rates.

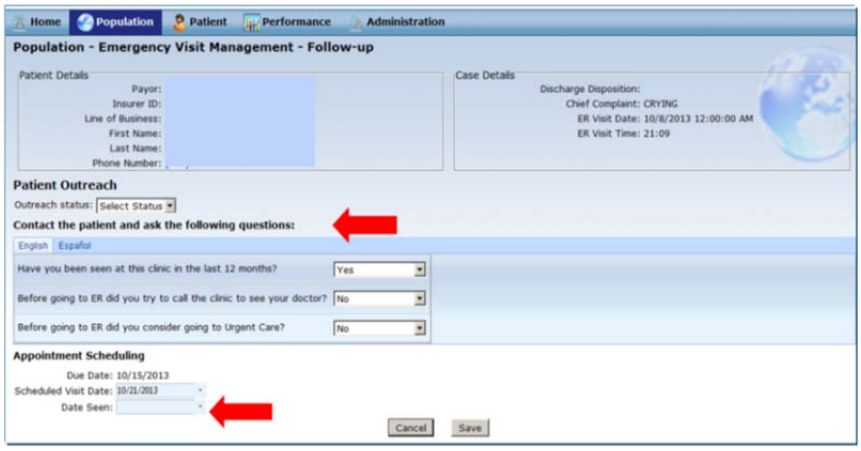

Figure 9. Population Registry screenshot displays the questions and workflow available to track the follow-up activities at a patient-level post-ER visit.

4) What incentives providers may have to improve care and health outcomes (e.g., withholds or incentive payments based on aggregate quality scores).

Based upon our analysis, the following VBP models are the specific financial and non-financial incentive models we have determined will best fit the Alaska provider landscape as we initially roll out the pilot program. These programs will allow us to align provider incentives to the activities that will drive the greatest opportunity to improve Alaskan care and health outcomes; improve integration between physical and BH; and address the unique needs of the CCDP population. They are fundamental to support moving network providers toward more ambitious VBP models. Model descriptions discuss payment structure, performance incentives and metrics.

- ***Primary Care Incentive Model:*** Our PCP incentive program focuses on closing gaps in care and improving quality outcomes that are critical to the State and CCDP members. This program includes key HEDIS improvement metrics that align with the State's quality objectives. Participating providers receive FFS reimbursement plus the opportunity to earn incentives for closing gaps in care. We will target qualifying providers, such as health centers and large pediatric and primary care group practices.
- ***Collaborative Care Model (CoCM):*** This program incents the incorporation of BH care management into primary care practices by providing a financial incentive to PCPs conducting BH coordination and collaboration activities. This program was developed to increase: 1) BH integration, 2) focus on PCP identification of BH management opportunities, and 3) coordination with the member's BH provider(s) and ongoing collaborative BH care management.
- ***Accountable Care Community (ACC) Model:*** We deploy our ACC model to link provider types such as PCPs, FQHCs, CMHCs and integrated health systems into a local community of care — in essence, a virtual accountable care organization (ACO). Our experience led to a realization that to achieve lower costs of care and improve

quality, we needed to help the primary care team collaborate and connect with other clinicians serving their patients in the same community — the hospitals and specialists who also serve their patients. Our ACC model is our core model that assists practices with transforming how primary care is delivered by incorporating six core pillars (or processes) into their practice including:

- Improving access to care
- Improving high risk patient care
- Reducing avoidable admissions
- Reducing non-emergent ER visits
- Improving quality and coding accuracy
- Improving growth and satisfaction

Providers may have an opportunity to receive incentive payments for completion of these clinical integration activities. In Alaska, we will work with qualifying providers to integrate these processes and programs into their practice based upon the goals and readiness of the provider and population health needs of the members they serve — assigning them a transformation consultant for clinical support and training, as well as enabling access to our web-based Population Registry for data sharing.

- ***PCMH Practice Support:*** We recognize the benefit of aligning the core organizational framework for primary care practices to PCMH principles, including a strong focus on care management, data analysis, performance measurement, continuous quality improvement, and sharing of best practices. Over the last decade, we have fostered the adoption of PCMH principles into Medicaid primary care practices. There are currently 21 PCMH-certified practices in Alaska, with nine located in our four selected service boroughs.

  Our incentives for PCMHs involve payments for infrastructure investments that can improve the quality of patient care. Because investments in these and similar delivery enhancements will likely improve member experience and quality of care, we consider this type of FFS or PMPM payment an important — though preliminary — step toward payment reform. As we have done with key provider associations across the country, we will actively partner with the Alaska Primary Care Association to align support and resources to increase adoption of PCMH models of care.

Once we have providers engaged in these VBP models, we actively support and collaborate with those providers to enable their success under their contract, including helping them improve performance, meet targets and build capacity levels. We will then transition them, as they are operationally ready, into our more advanced VBP models:

- ***Quality Shared Savings (QSS) Model:*** Our QSS model gives primary care practices with more than 1,000 of our members the opportunity to earn bonus payouts in addition to their FFS reimbursement for meeting or exceeding established quality measure thresholds. In addition, the program includes both upside/downside shared savings and shared deficit provisions based upon performance against total cost-of-care metrics.
- ***Accountable Care Shared Savings (ACSS) Model:*** This model targets larger private practices and FQHCs that are committed to collaboration toward a goal of clinical integration and comprehensive population management. Foundational to this model is advancing proactive care teams to support practice transformation by improving access, efficiency and quality of care for patients and to give practices the opportunity to earn monthly PMPM reimbursement for clinical integration activities. These monthly clinical integration payments are designed to support practice transformation and population management through proactive member engagement and monitoring of high-risk

patients. Our ACSS model focuses on engaging with providers to manage total population health that includes medical spend for hospital and specialty services as well as primary care.

The model includes both upside and downside shared-savings and shared-risk provisions based upon performance against total cost of care metrics. A menu of measures will align with the CCDP program and targeted populations, as well as Alaska-specific priority measures. Points earned for meeting performance threshold targets determine quality-improvement incentive payouts as well as shared savings/shared deficits distribution.

- ***Episode-Based Bundled Payment Contracts:*** For those providers not yet ready for total population health arrangements, we work with state Medicaid agencies to advance episode-based payment pilots. These programs typically focus on critical, high-cost conditions and procedures. They are intended to encourage collaboration among providers by aligning incentives across an entire episode of care. This approach rewards the primary accountable provider for a specific condition or procedure for quality and savings relative to market average benchmarks for the cost per episode, on a retrospective basis.

  In other markets, we have a long-standing history of employing this VBP methodology with our transplant service network. To become a provider in our Transplant Center of Excellence network, the medical center and/or program must demonstrate their proven experience and statistically successful record of accomplishment. For each transplant case, we provide the primary accountable provider with a bundled payment for kidney, lung, heart, liver or bone marrow transplant care provided to both adult and pediatric members. These bundled payments include not only the cost of the actual transplant admission, but also the organ acquisition fee and 90 days post-transplant care.

We also have incentives for non-medical providers, such as a program for BH specialists. Our Achievements in Clinical Excellence (ACE) program offers incentives to inpatient facilities and outpatient specialists who meet performance thresholds. We are an industry leader in the use of BH performance-based contracting and identification of the best-performing providers through both quality and cost metrics that offer transparent ratings to our members. For the inpatient program, participating providers with a minimum of at least 50 admissions annually are eligible for additional benefits and incentives and receive regular scorecards and consultation monthly to enhance performance. Outpatient providers must have a minimum of 10 patients annually to have a meaningful data set to review results. Metrics that guide our pay-for-performance reimbursement strategies are as follows:

Inpatient Metrics	Outpatient Metrics
▪ 30-day risk adjusted readmission rate ▪ Seven-day follow up after mental health hospitalization (HEDIS) ▪ Step-Up Rate: The percentage of patients who after stepping down from acute inpatient level of care to a lower level of care, then step back up to a higher level of care (at the same facility)	▪ Severity adjusted effect size from a member-reported wellness assessment tool, a peer reviewed tool that meets key reliability and validity constructs ▪ Case-mix adjusted average number of visits ▪ Average cost per episode

Providers achieving thresholds for these performance metrics earn reduced administrative burden, free CMEs/CEUs through *Relias Learning*, and increased referral volume through a premium *Platinum* designation achievement in our *Provider Directory.* ACE *Platinum* facilities and outpatient providers are identified with a ribbon icon, along with priority placement at the top of a search page, for easy identification by potential members.

Provider transparency and collaboration are key components of our ACE program. We have a dedicated team that meets regularly with providers to review scorecards (monthly for inpatient facilities) to review results and discuss interventions that would improve results, including the offering of technologies (e.g., text-based, email-based and voice-based reminders) to promote member adherence to treatment appointments.

5) Describe the approach to including essential community providers, such as community health centers, federally qualified health centers, and critical access hospitals in the provider network. Describe the payment model for these provider types and how they may vary.

We are sensitive to the importance of essential community providers in serving Alaska's underserved populations statewide and understand their network participation is vital to deliver high-quality, comprehensive care to the CCDP population. To identify and recruit essential community providers such as CHCs, FQHCs and critical access hospitals (CAHs) for our network, we will outreach to and encourage these providers who are currently enrolled in the State's FFS network to join our Medicaid network. For our essential community provider payment model, we will continue use of the State's prospective payment reimbursement model as well as include these providers in financial incentive models as applicable.

Credentialing and Contracting
We have developed credentialing requirements in accordance with the national industry standards as set forth by NCQA, CMS and State Regulatory bodies that are relevant to essential community providers, and we provide significant technical assistance to support these providers during Medicaid credentialing and contracting.

- We have reviewed the list of Alaska's 14 existing CAHs and none are located in our targeted service boroughs. If we expand our coverage area in the future, we will target CAHs in the expansion boroughs for network inclusion.
- We have targeted and are pursuing contracts with 12 FQHCs/CHCs for network inclusion in our selected boroughs, including the large Anchorage Neighborhood Health Center, Mat-Su Health Services, Sunshine Community Health Center and Interior Community Health Center.
- When contracting with I/T/U providers, we use the Indian Health Addendum, which formalizes our acknowledgement of their sovereign rights, and is frequently a prerequisite request of I/T/Us in contracting considerations. We will align reimbursement for these providers with the federal policy on Tribal Medicaid reimbursement.

G. Medicaid Managed Care Model: In accordance with the definitions provided in 42 CFR 438.2, identify under which managed care model the proposed project would operate (MCO, PIHP, or PAHP).

We are proposing to operate and currently qualify for the MCO model, in accordance with the definitions provided in 42 CFR 438.2. We will make the services we provide to our Medicaid members as accessible, in terms of timeliness, amount, duration and scope, as those services are to other Medicaid beneficiaries within the area we serve. Furthermore, we meet the solvency standards of §438.116, and we will operate our MCO delivery system in Alaska as authorized under Sections 1915(a), 1915(b), 1932(a) or 1115(a) of the Act.

H. Compliance with Federal Managed Care Requirements: Provide an assurance that the offeror is able to comply with federal requirements for an MCO, PIHP, or PAHP model, as applicable. If a proposal for an MCO, PIHP or PAHP is selected for consideration, the offeror will be required to provide detailed documentation of compliance with federal regulatory program standards and operational requirements for managed care plans during the negotiation phase of this solicitation process. Describe the proposed approach for addressing each of the areas listed below in the federal regulation subparts:

We will comply with the federal requirements for an MCO model. We have longstanding experience complying with federal MCO and managed care standards. We are very familiar with recently passed amendments to the federal Medicaid managed care rule. In each of the following subsections, we address the general standards set out in each federal regulation subpart and emphasize certain standards that we consider particularly important to a state, like Alaska, that is embarking on a new managed care program. In addition, we can provide documentation, if requested, of compliance with all federal regulatory standards and operational requirements for managed care plans during the negotiation phase of this solicitation process. Led by our national compliance director Kimulet Winzer (until a local compliance director is identified), our compliance team will work in conjunction with our performance excellence manager and senior plan leadership to ensure we meet all of the federal requirements for an MCO model. Using a contractual roadmap that identifies and records each contractual and program requirement, Ms. Winzer will oversee the our overall compliance with the Contract, program integrity and compliance-related functions covering the integrated services. She will manage our compliance with State and federal rules and regulations, preventing and detecting fraud, coordinating with the special investigation unit, and communicating with the CCDP's Program Integrity and Fraud, Waste and Abuse Unit of the Attorney General's Office.

1) 42 CFR 438, Subpart A (General Provisions)

2) 42 CFR 438, Subpart C (Enrollee Rights and Protections)

3) 42 CFR, 438, Subpart D (MCO, PIHP and PAHP Standards)

4) 42 CFR 438, Subpart E (Quality Measurement and Improvement; External Quality Review)

5) 42 CFR 43, Subpart H (Additional Program Integrity Safeguards)

Given our tenure and participation as an MCO in various state programs, we have developed robust quality and compliance programs and are familiar with compliance requirements governing MCOs to include 42 CFR 438 Subparts A, C, D, E and H, and will comply with these provisions consistent with federal requirements and contract provisions upon contract award. Our compliance program is based upon the seven elements of an effective compliance program, which includes all areas identified in Subpart H (program integrity requirements). The program ensures oversight and monitoring of all of our functional (operational and clinical) and delegated areas. The contractual requirements of Subparts A, C, D and E are standard, and we have identified and partnered with states to develop best practices in training and educating, for example, on areas such as advance directives, educating members on their rights including items such as freedom to choose a network provider and appeals and grievance rights mandated by federal law. As an established MCO, we have processes that meet federal and state requirements we are contracted to deliver to include encounter processes, fraud, waste and abuse provisions that allow us prevent, detect and correct any concerns when appropriate to do so, and work with states when their preference is to have referrals sent directly to them to investigate and/or prosecute.

We have processes in place in each of our markets to ensure that no individual or entity excluded from participation in government programs is allowed to participate. We partner with our state partners to ensure appropriate screening and disclosure processes are in place. Additionally, we ensure that whenever working with a delegate to perform services, we have appropriate contractual language that allows for oversight and monitoring to ensure that performance is consistent with our requirements under our contract with the State. We ensure that the Department's expectations of us are communicated to them and ensure they adhere to the contractual requirements to the same extent we do. We currently participate in State Quality and Assessment programs as well as external quality review organization (EQRO) reviews and are willing to partner to share best practices identified across the continuum of states we

provide service in to find the appropriate structure for Alaska, if desired. Upon contracting, we will be happy to discuss the outcomes of our audits as we have been quite successful overall. We welcome the opportunity to partner to improve programs and ensure expectations are met when needed.

I. Location of Operations:

1) Describe where the lead entity's headquarters will be located and whether satellite offices will be located in Alaska (and if so, where).

UnitedHealthcare's lead entity headquarters will be located in Anchorage, near the State offices to facilitate easy communication with the Agency. Our CCDP headquarters will be located in our current offices at 310 K St, Suite 700; 3333 Tarwater Avenue and 2524 66th Avenue in Anchorage, and at 801 W. 10th Street, Suite 300 in Juneau. We are leveraging our K Street Anchorage offices initially, and we will acquire additional space for our CCDP staff after contract award and prior to contract start. Our CEO, medical director and key staff members will be located in our Anchorage offices. We plan to employ approximately 200 Alaskans in these local offices to support CCDP member-facing services, as listed in the Key Administrative Functions and Respective Operational Locations table in response to Question 4.03.04.I.2.

2) Describe where administrative functions will be performed, including Member Services, Provider Services, Care Coordination, Medical Management, Quality Improvement, Claims Payment, Management Information Systems, Grievance and Appeals and Compliance. Explain the rationale for any functions that would be performed outside Alaska.

Our rationale for managing certain administrative functions outside Alaska, based upon our experience, recognizes that certain operations are performed more efficiently when centrally located. Our experience in many states has proven that certain functions provide economies of scale and maintain efficiency when centralized — specifically, provider and member call-center functions, claims processing and IT functions. These easily standardized functions can be efficient and responsive to state needs while taking advantage of our companywide infrastructure. All other member-facing functions, which are unique to this contract and designed to meet the specific needs of our Alaska members and providers, will be centered in Anchorage. Key administrative functions and their respective locations are listed in the following table.

Key Administrative Functions and Respective Operational Locations

Administrative Function	Location
Member Call Center	Albuquerque, New Mexico
Provider Call Center	Phoenix, Arizona
Care Coordination	Anchorage, Alaska
Medical Management	Anchorage, Alaska
Quality Improvement	Anchorage, Alaska
Claims Payment	Albuquerque, New Mexico
Management Information Systems	Minnetonka, Minnesota
Grievance and Appeals	Anchorage, Alaska
Compliance	Anchorage, Alaska

We staff our member and provider call centers, as well as our administrative function teams, with individuals who are familiar with Native American, Alaskan Native and Hawaiian Native cultures, as well as the challenges members who live in rural and frontier areas face.

4.02.05 Development, Implementation, Management, and Evaluation Plans (20 page maximum; not including GANTT charts and logic models)

Offerors must provide a comprehensive narrative that describes the project plan with timelines they intend to follow and illustrate how the plan will accomplish the proposed project's objectives and meet the project's schedule. Include the following:

A. Provide an implementation plan and timeline that covers the period from selection for the development phase through initiation of enrollment. Assume for the purpose of the timeline that selection will occur by July 1, 2017 and that enrollment will be initiated by January 1, 2018. Include:

1) A description of offeror's major development/implementation tasks;

Implementation Plan and Timelines

We will use a comprehensive implementation work plan — provided as Attachment 4.02.05.A - Implementation Project Plan — that guides our preparedness and readiness to perform the requirements of this contract. The work plan identifies the detailed steps, accountabilities and time frames that must be met to achieve timely implementation of our proposed MCO model, assuming an anticipated Jan. 1, 2018, Contract effective date. The summarized timeline highlights the transition activities and critical milestones required to successfully implement the systems and system changes to support the CCDP and serve members, providers and the Department from day one of operations.

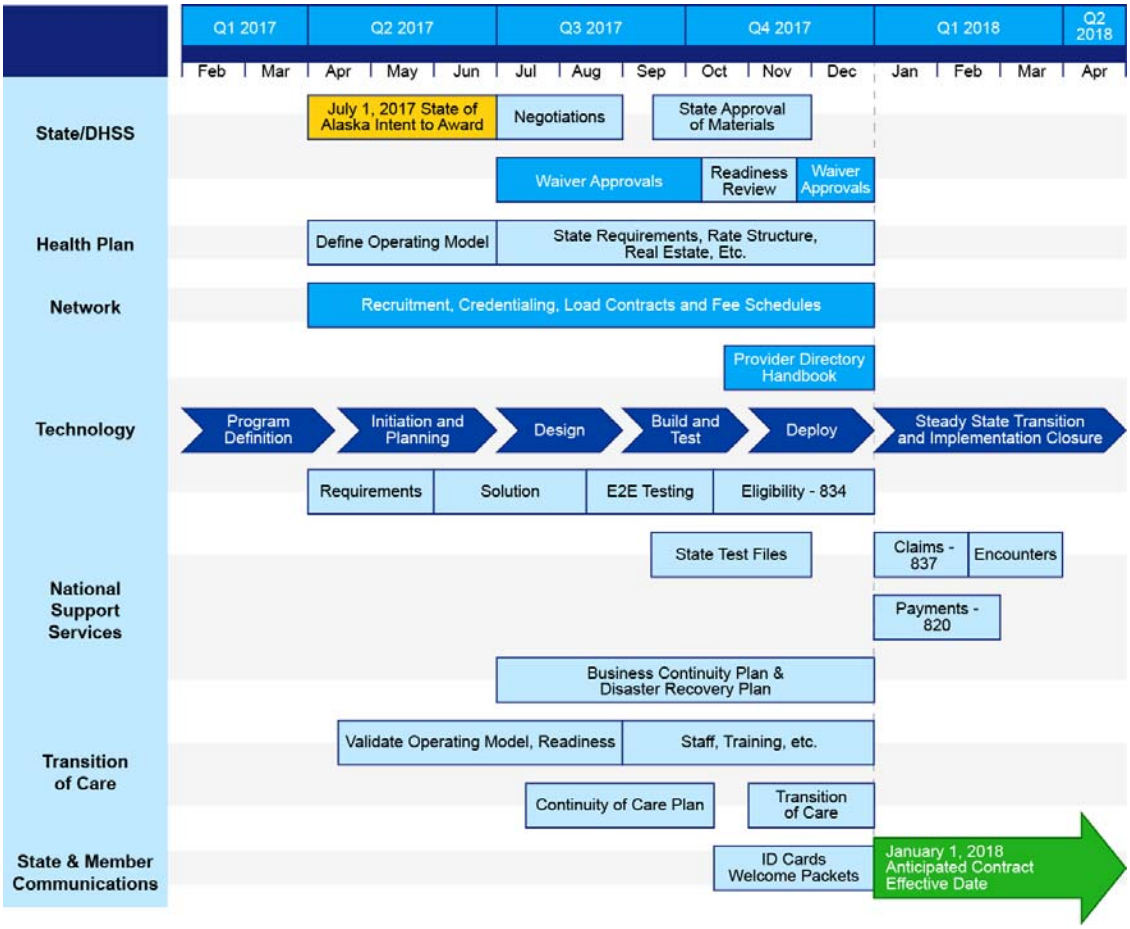

Figure 10. Assuming a July 1, 2017, selection date and a Jan. 1, 2018, Contract effective date, our implementation timeline depicts the major implementation tasks to complete to achieve State of Alaska and internal readiness metrics for the CCDP.

Experienced Implementation Leadership Dedicated to Alaska

In new Medicaid markets, such as Alaska, the CEO leads the implementation and is supported by our market executive director and our national Implementation and Business Alignment (IBA) team. The implementation leadership team for Alaska's CCDP is committed to a seamless program implementation. They will work closely with the Department on all aspects of plan implementation, communicating with the Department stakeholders often and in a timely, effective manner. This will include working closely with the Department to update the project plan to include the Department's input.

We will lead the overall implementation effort from our Anchorage office. Chief executive officer Douglas Bowes and market executive director David Rossi will draw additional support and staff resources from our national IBA team to leverage the diverse skillsets related to the management of deliverables and to create a consistent implementation experience focused on quality. We have a successful track record of responding to expanding staffing needs and we plan to hire locally.

CCDP Implementation Support Locally and Nationally

Implementation manager Lora McClanahan is the national IBA team lead who will work closely with Mr. Bowes and Mr. Rossi and other members of our Alaska-based leadership team on all aspects of the CCDP implementation project. Ms. McClanahan will collaborate with Mr. Rossi regarding communication with State stakeholders and the Department, and she will make sure we provide the Department with an updated work plan on a monthly basis. We selected Ms. McClanahan for the CCDP due to her experience and implementation skillset. She has over 20 years' experience in the health care industry and over five years' experience in leading new Medicaid program implementations for UnitedHealthcare.

In concert with this RFP submission, Ms. McClanahan orchestrates the IBA team's health plan set-up projects, activates implementation work-plan tasks and builds out the critical elements required for a successful implementation and in preparation for the onsite readiness review. Our national IBA team also will provide training for the local team and stays with the local team as needed until the plan is fully staffed, trained and operating smoothly.

Major Development and Implementation Tasks

Based upon CCDP requirements, anticipated schedule of effective dates, and the Department's readiness review activities, we have prepared a high-level implementation summary that depicts this project's major milestones, tasks to be completed and functional areas accountable for completing the major task. While our full project plan provides a complete list of implementation activities, the following table depicts the key implementation activities we have identified and scheduled for completion prior to the readiness review.

Implementation Task	Task Start	Task Finish	Functional Area
Alaska CCDP Project Timeline	04/01/17	04/30/18	
Project Preparation Milestones	04/01/17	01/01/18	
Open Enrollment	10/01/17	12/31/17	Local Health Plan and the Department
Staffing	06/01/17	12/01/17	Human Capital
Health Plan Offices	08/31/17	12/01/17	Real Estate
Implementation Readiness Review	10/02/17	10/27/17	Implementation Team and Local Health Plan
Functional Team Readiness	04/01/17	02/02/18	
Outreach/Communication/Marketing	07/01/17	12/31/17	Local Health Plan
System Configuration	08/15/17	11/01/17	Benefit Configuration

Implementation Task	Task Start	Task Finish	Functional Area
Compliance Readiness	04/17/17	12/31/17	Compliance
Finance	10/01/17	12/01/17	Finance
Information Technology (IT)	04/17/17	02/01/18	IT
User Acceptance Testing (UAT)	11/01/17	12/15/17	All Functional Teams
Regulatory and Operational Reporting	09/01/17	11/15/17	Business Intelligence Reporting Team
Clinical	04/17/17	12/15/17	Clinical Team
Member Materials	10/01/17	12/15/17	Member Communications Team
Member Call Center	09/01/17	01/01/18	Customer Service Team
Member Portals	09/01/17	10/01/17	Web Portals Team
Enrollment/834 production file	10/01/17	12/31/17	Enrollment Team
Claims	11/01/17	01/01/18	Claims Team
Appeals and Grievances	11/01/17	01/01/18	Claims and Clinical Teams
Network Readiness	04/01/17	11/01/17	Network Team
Provider Call Center	11/01/17	01/01/18	Provider Services Team
Provider Portals	01/01/18	01/01/18	Web Portals Team
Housing Assistance	09/01/17	12/31/17	Local Health Plan
Pharmacy Operations	07/01/17	01/01/18	Pharmacy Team
Vendor/Subcontractor Readiness	11/01/17	11/01/17	Vendor Management Team
Encounter Data/Submission	12/22/17	12/22/17	Encounters Team
Alaska CCDP Project Enrollment Initiation (anticipated)	01/01/18	04/30/18	All Functional Teams
Performance Guarantee/Operations Metrics Monitoring	01/01/18	04/30/18	Implementation Team/Local Health Plan

We apply our national experience and lessons learned to tailor each implementation to meet the needs of the local market. Our approach reinforces minimum disruption to members and providers by understanding and anticipating issues that may affect them and providing timely resolution of those issues.

Comprehensive Service Model

Our service model and approach to delivery will provide the Department with a rich resource of Alaska-based partners with the necessary skills and competency to meet program needs — now and in the future. Our primary focus is on members and ensuring continuity of member care in collaboration with providers. We implement a continuous improvement process to evaluate implementation performance while maintaining close communication with State stakeholders. We rely on a comprehensive suite of project management tools (e.g., stage gate reviews that assess project status and quality) that verifies each functional team (e.g., member services, provider services, clinical, technology, operations) simultaneously achieves the milestones assigned to it, yet stays connected on those active interdependencies across multiple functions. Our disciplined implementation approach comprises several key components, including:

- An implementation governance structure for effective management of implementation tasks and communication with the Department
- Internal and external dependency management that allows us to quickly adjust and modify our approach based upon potential and actual delays

- Internal readiness reviews in advance of the Department readiness reviews that prepare us to meet the Department's readiness review requirements

Implementation Project Management Expertise

Since 2014, we have implemented new contracts that provide services for new or expanded state populations using industry-recognized Project Management Body of Knowledge (PMBOK) methods. In these markets, we have successfully transitioned member populations that include Medicaid, ABD, TANF, CHIP, LTSS, I/DD and other programs that support individuals with complex, high-risk health care needs. As a result, we have the knowledge and capacity to minimize issues, risks and challenges during implementation while maximizing long-term viability, success and value to CCDP members, providers and the Department.

We apply PMBOK project management principles and techniques to project implementations within our stage gate framework. Techniques include project governance, project plan management and action item, risk and issue management. The stage gate method provides an end-to-end internal framework to review and monitor dependent requirements, confirm status details, and identify potential risks and issues. We use a SharePoint project portal to maintain all project artifacts, detailed requirements and business communications, and provide access to all project resources.

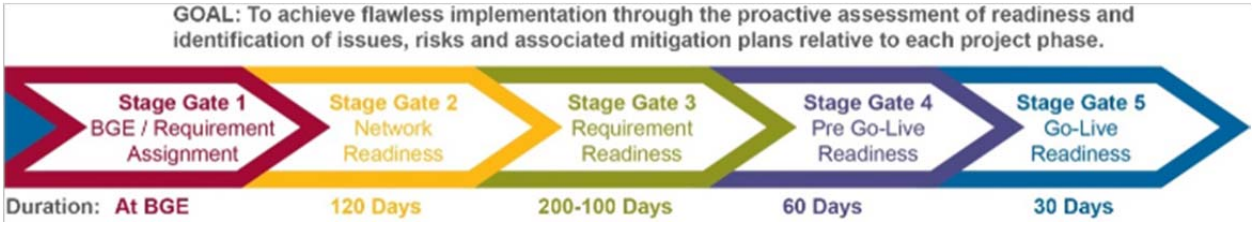

Figure 11. Using PMBOK stage-gate techniques, we achieve readiness with every project no matter project size or implementation time frame. (Note: BGE = Budget Guidance Estimate regarding IT systems.)

The stage gate framework consists of:

- ***Stage Gate 1 – Requirements Assignment:*** The project startup phase begins at the proposal submission. At this first stage gate, we complete a detailed walk-through of contractual requirements, RFP commitments and communication with all operational teams that will support RFP requirements and cost estimations.
- ***Stage Gate 2 – Network Readiness:*** We review network status at several stage gates, but we use this focused full network review to confirm requirement delivery, identify contractual status of all providers and finalize go-live communication strategies.
- ***Stage Gate 3 – Requirement Readiness:*** Stage gate 3 is a detailed review of requirement progress — used to adjust any go-live contingency plans — risk mitigation, or proactive discussion of member transition planning.
- ***Stage Gate 4 – Pre Go-Live Readiness:*** At 60 days before go-live, the implementation team assesses operational readiness across all functions. We review detailed go-live monitoring plans, with contingency planning to accommodate potential risk.
- ***Stage Gate 5 – Go-Live Readiness:*** At 30 days before go-live, the national IBA team assesses any changes in operational readiness across all functional areas and any use of manual workarounds.

The stage gate process allows us to create an overview of the end-to-end experience of our members and providers. It also helps us to understand and anticipate possible disruption points that may occur (e.g., new requirements, providers or contract changes) and mitigate any

disruption. We then create specific contingency and communication plans to proactively address these issues. Because of transitioning more than 1 million members in the past three years, we have a broad scope of experience from which to draw upon, and we continually incorporate lessons learned, adjust our project management techniques and develop best practices for future implementation projects.

Implementation of Technology to Support the CCDP Program

We will configure and test Our Facets Community Strategic Platform (CSP) technology and surrounding applications to support Alaska's CCDP. Our approach will focus on five key program management elements during the implementation:

- ***Critical Path and Timelines:*** Document early our critical path milestones and the timeline required for defining, developing and testing the technology before go-live
- ***File Formats and Companion Guides:*** Work together to develop agreed upon file formats and companion guides that clearly define the integration requirements
- ***Detail Design and Development:*** Develop detailed design documents with input from all key stakeholders to confirm the development outcome meets the integration needs
- ***Test Files and Testing:*** Develop test files and test scenarios, considering all possible inputs and outcomes. Conduct full end-to-end testing
- ***Go-Live Coordination:*** Team dedicated to coordinating the successful launch of the integration with key stakeholders on call for critical issue resolution

Our project team approach is based upon our successful experience effectively implementing programs of a similar scope and size across the country.

Results-Oriented Project Governance

We use the framework of our governance and project management approach to confirm our active monitoring and tracking of implementation progress and the quality of our deliverables to meet contract requirements. To effectively communicate with the Department during implementation, Mr. Bowes and Mr. Rossi will be the primary points of contact with the Department stakeholders and will manage all communications with the Department.

Our approach to project governance, the framework for making critical implementation decisions, is foundational to our ability to deliver program value. Project governance encompasses the following elements in support of a fully executed implementation plan that delivers the anticipated operational and member-facing benefit:

- Identifying, tracking and resolving issues
- Contingency and mitigation planning
- Transition management
- Implementation work plan
- Tracking and managing implementation progress

Our project governance model documents and provides clarity on critical decisions, escalation and assignment of accountability to decision makers. The result is an implementation plan executed in a way that delivers the anticipated benefits.

Tracking and Managing Implementation Progress

We conduct reviews throughout the project to identify potential risks and issues using the IRAAD tool — Issues, Risks, Analysis, Action and Decisions. Our approach to project management relies upon a single organizational structure that combines a local Alaska-based,

implementation model with national resources and support. It encompasses an innovative technical approach, a robust network strategy for integrated medical and BH care services, and a comprehensive approach to staffing and staff training. Using this model, we are able to create a more consistent and proactive process that leverages the resources of our entire implementation team. Our implementation strategy will operate under these primary principles:

- Deliver exceptional care to CCDP members
- Support member choice and ability to live in the least restrictive, integrated setting
- Make sure members experience minimal disruption of service
- Implement health care delivery improvements and innovation to improve population health and deliver cost savings for the State

The implementation of a health plan requires coordination of multiple deliverables both inside and outside of UnitedHealthcare. **Our internal readiness review model also holds our material subcontractors to the contract readiness, compliance and quality standards of our functional teams.** This thorough approach takes into account and measures our adherence to the readiness review schedule and our level of preparedness to review all processes and upcoming milestone dates and activities with our state partner.

To manage potential risks or barriers to implementation, our Alaska implementation team will use the IRAAD tool for business and technology items. We assign items out to the front-line business owner, with a date assigned for resolution and escalate issues, as appropriate, to the applicable team for resolution. We conduct reviews throughout the project to identify potential risks and issues and use the IRAAD tool to monitor outliers.

Readiness Reviews

We have detailed processes to make certain the State has a complete overview of all implementation and go-live activities. As part of this process, we request feedback from our State partners to refine the readiness review process as part of continuous quality improvement.

In the past three years, we have participated in 36 desk readiness reviews and 30 on-site reviews. We will prepare for, and participate in readiness review meetings and bring the depth of our experience to demonstrate operational readiness in accordance with contract requirements.

As we enter Alaska, we plan to build upon the strength of our Medicaid managed care infrastructure and robust operational capacity that distinguishes us and provides a platform for the innovations we promote. During readiness review and beyond, we welcome the opportunity to collaborate with the Department, members, providers, stakeholders, other state agencies, MCOs and community groups to demonstrate our ability to serve as an agent of transformation in the Alaska health care system.

We understand that readiness reviews are an essential component of our implementation planning process, and we agree to comply and collaborate with State-readiness review requirements. We will undergo and pass a readiness review process at the State's discretion and will be ready to assume responsibility for contracted services on the agreed-upon Contract effective date. To verify our operations can effectively execute the transactions necessary to meet member expectations and the Department requirements, we:

- Assign a team dedicated to managing the readiness review
- Identify subject matter experts
- Compile the required Department and/or CCDP documentation by due dates

- Develop materials and presentations that reflect CCDP requirements
- Respond quickly to the Department needs and meet all deadlines

Internal Readiness Review Meetings

Based upon contract requirements, our dedicated team develops a summary version of the overall project plan that provides a detailed and complete overview of all implementation and go-live activities. We regularly conduct internal readiness-review status meetings to compare our readiness to date alongside the implementation plan effective date. This measures our adherence to the readiness review schedule and our level of preparedness to review all processes and upcoming milestone dates and activities with our state partner. Key items that we review during these internal status meetings include, but are not limited to:

- Enrollment data management processes
  - Loading of member enrollment files and distribution of member onboarding materials, handbook and member ID cards
- Claims management processes
  - Monitoring of go-live items to verify system, plan and services are at a steady state and meeting service levels
- Clinical programs and care transition planning processes
  - Prior authorization systems entry for members with existing approved prior authorizations
  - Welcome calls and Health Risk Assessments (HRAs) are completed
  - Clinical team completes continuity of care plan work, and outreaches to high-risk members
- Status of technology system development and testing
  - Member and provider services call centers move to operational status prior to effective date to answer calls, typically in support of provider assignment and/or continuity of care
  - End-to-end system validation of all impacted systems
  - Submission of encounters and other required files
  - Web access and portal setup — launch of member and provider portals

State Readiness Review Meetings

We will be prepared for various types of readiness reviews with the Department, such as:

- Paper readiness review where the Department asks questions or requests information (e.g., policies and procedures, staffing plans, training curriculum and cultural competency plans)
- On-site testing readiness review where the Department visits our local facilities to assess our functional readiness (e.g., call center) or to conduct an audit or an interview of our personnel (e.g., member services center representative)

Successful Implementation Record
In the past three years, we have successfully participated in 36 desk readiness reviews and 30 on-site reviews.

After the readiness review, our dedicated readiness review team will obtain integrated feedback from the Department and will incorporate it into our implementation plans, including updating operational processes and procedures to execute the contract.

CMS Review

We understand and acknowledge that our operations relating to providing services under this contract are subject to review and approval by CMS, and we will comply with any requests received from CMS.

Summary

Our overall implementation work plan is organized into functional segments, each with a dedicated implementation team that focuses on their specific component of the implementation, including applicable ancillary programs. Each functional implementation team reports to the implementation lead, who confirms operational readiness, contract compliance and proper alignment of resources and staff.

2) A description of potential barriers to implementation based on the offeror's relevant experience and approach to overcoming these barriers;

One example of a potential barrier is based upon our experience with states rolling out Medicaid managed care for the first time is lack of a fully contracted provider network prior to readiness review. It is not uncommon in brand new Medicaid managed care markets to have providers who are not fully supportive of the state's decision to move to managed care or who wait until after awards are announced to make a decision to join the MCO's network. To minimize this barrier, early in the process we dispatch our network team to meet with providers and engage them in the network participation discussion. The team's work helps to reduce concerns the provider community may have regarding the changes in the Medicaid program's administrative procedures and claims payment rates. In addition, in new markets, it is common for providers to be slow about completing and submitting applications. To mitigate the impact of such network issues to members and the implementation process, we increase our interactions with providers and include our leadership in the discussion. We keep our state partners informed of these situations and involve them when appropriate. If the provider is not contracted but key, we will enter into letters of agreement and/or single case agreements to facilitate continuity of care and uninterrupted services for members.

A seamless transition experience for every member and provider is our No. 1 goal.

Another potential barrier we have encountered, based upon our extensive experience with new health plan implementations, is the timing of the first 834 enrollment file transfer. It is critically important to load this initial enrollment file correctly and to ensure that enrollment information flows to the appropriate systems correctly so member materials are mailed timely. Therefore, to overcome this barrier, we build in additional time to upload this first file compared to the ongoing files. Receiving the first 834 file at least 30 days prior to the go-live date is preferable and enables us to perform downstream member outreach activities in a timely manner. Receiving ID cards in advance of their effective date will be especially important for the members served through the CCDP, particularly for members currently receiving services, needing prescriptions filled and those who have scheduled appointments. Sending and loading the 834 file earlier will enable us to produce and distribute ID cards in batches and to manage the related influx of calls that ensue when members receive new ID cards and transition to this new program. We typically work with the state to develop the file timing in a new program launch scenario.

Another potential barrier could surface due to waiver approval timelines. While we do not anticipate it as a barrier in Alaska, we recommend the timing of the program go-live date be adjusted as needed to account for any waivers awaiting CMS approval. Normally, waiver approval processes take approximately six months from the time a state submits a waiver to

CMS. Any unanticipated delay affects the implementation process and adjusting the go-live date when delays occur would be prudent to maintain the integrity of the implementation project.

Finally, with an implementation of this magnitude, any delays in the contract negotiation or execution process could create a barrier to timely implementation and has the potential to slow downstream implementation and program set-up activities. This includes delays on the State's part in forwarding information about ancillary providers or vendors providing care management services and delays in receipt of rates paid to providers. Delays in providing pertinent information about the existing care and services members are receiving could result in delay of implementation deadlines.

We are committed to making any transitions or changes as smooth and transparent as possible for the people we serve and the health care providers and caregivers who serve them. Through our project team approach, we assess and manage project risks based upon our experience and understanding of the State's program. We have project management staff that quickly assess problem situations and coordinate the development, execution and monitoring of work plans to mitigate implementation risks.

3) Based on the offeror's relevant experience and knowledge, describe what the offeror believes the major State and DHSS implementation tasks will include, related potential barriers to implementation, and how the offeror will assist in overcoming these barriers; and

THE MAIN NEEDS: MUTUAL TRUST, COLLABORATION AND ENGAGEMENT

We are an experienced Medicaid program manager and we have successfully implemented Medicaid managed care health plans in 24 states. Our nationwide Medicaid managed care footprint was not formed by accident. Rather, our success can be attributed to our commitment to serving our state partners and our transition processes and procedures that effectively align Medicaid beneficiaries with their new care management organization. Our approach to transitioning CCDP members will be proactive, beginning with our efforts to establish and maintain a strong partnership with the Department to carry out Alaska's Medicaid program goals, including its reform initiatives established in SB 74, as our foundational endeavor.

At the forefront of every implementation is securing continuity of care for members during and after their transition to our program. Through our experience, we have learned a number of important lessons regarding successful transitions:

- Establish a committed leadership team
- Develop a clear vision of the end goal
- Install a governance structure that enables timely decision making
- Invest the time "up front" to thoroughly plan the work effort
- Deploy a dedicated transition team with the right resources to execute the work
- Collaborate and communicate frequently with State stakeholders, members and providers
- Implement a robust project management infrastructure

Because all members and providers in Alaska will be transitioning from a FFS program to a managed care environment, it will be critically important for the Department and our leadership team to collaborate and communicate often to proactively identify and address implementation tasks that are unique to this particular project.

We seek transparency in our approaches, operations, negotiations with providers, community organizations and with the Department. During the implementation, we appreciate the

opportunity to interact with the Department on a regular basis, and we will follow all protocols for communication, and information collection, distribution and management. We prefer to collaboratively create an accountability matrix that clearly articulates key interaction, decision and communication protocols for efficient and effective interactions between the Department and our contract management team leaders.

Major State of Alaska Implementation Tasks

We believe the main tasks for the Department and the State to consider regarding implementation center around preparing members and providers for the transition from Alaska's current FFS system to a managed care model. Whenever such changes take place, people and providers want to know how the change will affect them. They have questions. They often have preconceived notions and fears about the transition resulting from hearsay and by talking with one another. We believe the State needs to address the public's concern about this change in a transparent way to quell the fear of change and to gain support from members and providers regarding the State's decision to transition to this new model. In our experience, communicating early, often and using simple, brief instructions and easy-to-understand terminology with members and providers is the most effective approach to preparing the public and providers for the change that also will lead to a quiet and smooth transition experience for all involved.

Key Implementation Tasks for the Department

As we move through the implementation cycle in preparation for the anticipated Contract effective date of Jan. 1, 2018, and subsequent program go-live date, we have identified the following steps the Department will need to take to keep the implementation on track:

1. Engage the Department IT team with UnitedHealthcare's IT team to begin working on all data exchange and infrastructure within 30 days of State's notice of intent to award
2. Provide executed final contract within 60 days of State's notice of intent to award
3. Provide the data file companion guides within 60 days of State's notice of intent to award
4. Communicate all readiness review required deliverables 60 days in advance of the readiness review dates; both desk and on-site readiness
5. Provide all required reporting templates 90 days prior to go-live
6. Provide the pharmacy drug list and clinical prior authorization list 90 days prior to go-live
7. Review and approve member materials, such as handbooks, welcome packet materials, ID cards, letters and EOB within 30 days of our submission to the Department; with approval notice to us no later than 90 days prior to go-live
8. Review and approve provider materials, such as administrative manuals, provider directory, within 30 days of our submission to the Department; with approval notice to us no later than 45 days prior to go-live
9. Transmit test enrollment 834 file no later than 45 days prior to go-live and initial production enrollment 834 file no later than 20 days prior to go-live
10. Forward data regarding current vendors performing care management services for members, including any information about member's current treatment plans, the provider network, pharmaceuticals members are receiving, and inpatient members 15 to 30 days prior to member's effective date with our program

With an implementation program of this size, it behooves the Department to adjust certain implementation due dates in the event the Department delays an implementation deliverable.

For example, if the contract negotiation and execution date is delayed, then the go-live date should be delayed accordingly so that downstream implementation efforts and deliverables can be completed within budget and according to the original timelines proposed for completing each implementation task. Delay with receiving any of the elements needed from the Department could result in delay of the implementation deadlines.

How We Assist States in Overcoming Implementation Barriers

We work in collaboration with our state clients to overcome implementation barriers by building applicable activities into our transition process that take into account geographic, technological and cultural needs and the access-to-health care concerns of members and providers. Our transition process is a multifaceted, whole person care approach. We focus on goals encompassing risk mitigation, and coordination, communication and uninterrupted treatment for all stakeholders. Our transition planning goals and objectives are the result of 33 years of experience serving vulnerable Medicaid populations and achieving improved health outcomes.

Collaborating Early and Often Regarding Enrollment File Transfers

Throughout our implementations, we have found that a focus on enrollment and eligibility data are the first key data exchanges that should be specified, tested and deployed for two reasons. First, eligibility and enrollment testing is a prerequisite to later claims submission, authorization and pre-processing testing. The second is the need to go-live with enrollment processing well before the actual plan go-live date, to allow for member communications, ID cards, outreach activities and clinical transition activities.

Outreach to New Members

Persons new to our health plan, or new to managed care, often have questions about benefits and need assistance with finding/changing PCPs. Our new member welcome team conducts new member welcome calls to enhance member engagement as well as gather timely information to help provide personalized service. New members will receive a welcome packet containing details about their covered benefits and providers in the network, as well as information via welcome calls that our member services staff will make within the first 30 days of their enrollment date with our plan, or as required by the Department.

With every welcome call, we:

- Verify the member has received his/her ID card and the welcome packet
- Review covered services to make sure members understand their benefits and to answer any questions they have regarding benefits
- Explain how the member can and should access covered services
- Conduct an HRA
- Assist members with scheduling doctor appointments and establishing a relationship with their PCP; or assist them with changing PCPs if they desire
- Educate members on the importance of obtaining preventive care and more

We identify persons who require alternative formats for written materials and translation/interpretive services. We assist members in securing transportation services. We identify other necessary services, such as dental visits, to promote overall member health.

Early Outreach to High-Risk Members

Because early identification and intervention are critical for managing the care of high-risk members, our protocols focus on identifying and reaching out to members who may benefit from additional assistance during transition and provide oversight and guidance to verify that we

maintain continuity of care. This includes proactively tracking prior authorization information in our system and establishing a more aggressive approach to continuity of care for these members. Early notice from the Department regarding incoming members having one or more of the following risk cohorts will help us to proactively triage our care coordination and continuity of care efforts:

- Members with care plans and home health supports
- Members who are currently hospitalized
- Members recently discharged and/or in transition care
- Pregnant women who are high-risk and in their third trimester
- Members who have experienced major organ or tissue transplantation
- Members who are undergoing chemotherapy or radiation treatment
- Members with chronic illness that has placed them in a high-risk category for hospitalization or placement in nursing or other facilities
- Members needing specialized DME services
- Members with authorized procedures post-transition
- Members receiving ongoing outpatient treatment, including BH, recovery and rehabilitation services

To prioritize care coordination for these members, we use state-supplied prior authorization and claims history reports, if provided. Claims history is critically important because it enhances our ability to maintain continuity of care for members. We identify members in active care management programs or care plans using this information. Care managers reach out directly to vulnerable members identified by these sources, to confirm ongoing services and provide valuable transition information to these members. Based upon our understanding of these members and our experience in providing the coordination necessary to support their successful transition, we proactively manage all aspects as described in the table:

Implementation Transition Timeline	Key Activities for High-Risk Member Transitions
30 Days Before "Go-Live"	▪ Receive/review prior authorization and claims data files from state agency. ▪ Receive/review any care gaps, provider gaps and gaps in transportation availability to proactively manage access to care.
	Notify key provider groups of the continuity of care and "go-live" processes for members who are potentially impacted (e.g., oxygen, dialysis, scheduled procedures).
"Go-Live" to 30 Days Post-Implementation	Confirm readiness linking with the call center to monitor and streamline the resolution of any go-live issues for member care.
	Contact members upon initial enrollment file and state approval for critical care management.
	Assist members and providers with "go-live" transition questions and immediate needs. In the first week of any new plan launch or expansion, heavy use of pharmacy services is expected. We will prepare the call centers to respond to this temporary volume increase.
	PCP changes: If our member prefers a different PCP, we will make these changes.
	Case management outreach continues for vulnerable members, and begins for members who are in lower risk categories.

When transitioning members with care plans, we use a separate staffing plan model that allows us to prioritize (e.g., based upon level of care or high utilization) and track members within the time frames required by our state partners. If necessary, we secure additional staff from our affiliate companies to support the volume of member reviews required. To verify continuity of

care, we analyze our provider network to determine any network gaps for these members, and make every effort to contract with new providers.

We understand the importance of creating a solid foundation of care for every transitioning member. Our approach to transition focuses on making sure members receive care and assistance at all points in the process. We have successfully accomplished this with other state partners as described:

- In 2016, our Arizona health plan seamlessly transitioned over 63,000 Maricopa Integrated Health Systems enrollees in a way that was so impressive to our state client that they have adopted our project framework and our approach for any similar effort going forward.
- In 2015, through our MississippiCAN program, over three months we transitioned nearly 150,000 members from FFS to managed care by assessing resource needs, analyzing risks and executing a well-developed plan, resulting in a smooth transition and seamless continuity of care for our newest members. We also assisted the State in transitioning adults with I/DD while the State was awaiting waiver approval. Although these were enrolled individuals, the request was to cover a new service not covered under our contract. We amended provider contracts to cover these new services and updated our claims system to pay the claims.

Addressing Implementation Barriers with Providers

We have experience with and understand the importance of working closely with providers during every transition. Our approach to transition focuses on making sure providers — including ancillary providers and subcontracted vendors — receive proper training and assistance with claims and care coordination activities. We form provider advisory councils as a venue to build meaningful relationships with the local provider community and to develop programs that address provider needs and mitigate concerns. The strength of our provider relations approach is the ability to support providers via strong integration with our operations and clinical teams — proactively identifying, communicating and resolving operational or clinical concerns and mitigating provider concerns. We first identify the issues and concerns facing providers and then employ strategies and tools to help providers new to or unfamiliar with such activities as claims submission and prior authorization requirements to navigate through the managed care environment.

Our provider relations team uses accessible, in-depth and tailored provider education to create seamless onboarding of new providers. They conduct both in-person and web-based training to assist hesitant providers, as well as use established educational tools and support processes dedicated to helping new providers understand managed care systems.

4) A Gantt chart or equivalent planning tool that outlines respondent implementation tasks and subtasks by functional area, including expected start and completion dates.

We provide a detailed implementation plan as Attachment 4.02.05.A – Implementation Project Plan.

B. Provide an estimate of the offeror's projected development and implementation costs and describe how the offeror will fund development and implementation in the absence of development and implementation funding from DHSS.

Development and Implementation Costs

We estimate development and implementation costs of $9.0 to $11.0 million including, but not limited to, the following expenses:

- Hiring, onboarding and training of staff prior to contract go-live
- Non-workforce-related costs (real estate investments, recruitment, marketing, print, postage, telecom, supplies, etc.)
- IT systems/infrastructure investments

Our intention with regard to development and implementation costs that arise is to fund the requirements from ongoing cash flow from operations. We plan to recover the development and implementation costs through cost savings driven by implementing the various managed care activities outlined in our proposal while still meeting our goals of savings to the Department.

UnitedHealthcare is part of UnitedHealth Group, which has the financial resources for UnitedHealthcare to meet all financial obligations. In the event of an immediate and material cash demand, a surplus infusion in the form of cash will address cash requirements. In the case of a short-term and immaterial cash demand, we may use revolving credit with our parent, UnitedHealth Group.

C. Describe any State statutory or regulatory changes necessary for implementation of the proposed model. Note that the Gantt chart should take into consideration the time necessary for enactment of such changes, if applicable.

To the best of our knowledge, the necessary authority to execute contracts for this program is contained in SB 74 and the Department's overall authority to administer the Medicaid program. Therefore, it is our belief that no statutory or regulatory changes will be necessary for implementation of the proposed model.

D. Describe any federal authorities, including waivers, necessary for implementation of the proposed model. Note that the Gantt chart should take into consideration the time necessary for obtaining a waiver, if applicable.

Our proposal will operate under a CMS 1915(b) and 1915(c) waiver. CMS will need to approve a 1915(b)(1) Managed Care waiver and an amendment to the State's current 1915(c) waiver. We anticipate approval of these waivers to take approximately six months from the time the State submits to CMS.

E. Describe the methodology the offeror will use to evaluate the quality of care, effectiveness and outcomes of the demonstration project. Include the following:

We have established a methodology to monitor and evaluate the quality of integrated medical and BH care delivery, administrative effectiveness and improved health outcomes, based upon contractual, regulatory and clinical requirements. First, we establish provider, population and member health, and cost performance metrics that directly correspond to the State's contract goals and thresholds. For example, these metrics include HEDIS and CAHPS scores for care delivery and satisfaction, and return on investment (ROI) calculations for programmatic effectiveness assessments. Then, we assess our current operations and adjust our processes to meet the State's operational cost and health outcomes requirements, comparing current activities and historical trends to required outcomes. We report our findings at contractually required intervals (monthly/quarterly/annually), which are submitted to the State, along with a plan for corrective action, as needed. We also share information with our network providers to evaluate and improve member care and network provider performance.

1) A logic model for the project.

Our logic model illustrates how our MCO is expected to produce the desired outcomes. It examines selected activities related to each of the four CCDP components we are measuring: improved cost effectiveness, access, health outcomes and population health. It also addresses the Department's three service priorities: health and wellness across the lifespan; health care access, delivery and value; and safe and responsible individuals, families and communities.

The logic model reflects the priorities, initiatives, interventions and outcomes of a successful, integrated MCO care delivery system. As we apply it to the CCDP, we look at each operational aspect of our proposed MCO model and identify prospective problems or challenges; provider, member or operational interventions; and the ultimate outcomes that represent success to the State. For example, the MCO model evaluates person-centered care in a provider practice where we need to visualize complex interventions, employing multiple components that interact across multiple levels. We use the logic model to offer guidance in the development of critical intervention measures that directly affect our member, network provider and operational efficiency outcomes. It visually clarifies goals and critical issues, allowing us to identify conceptual gaps at the beginning of the intervention.

Implementing the Logic Model in Alaska

Implementing an MCO logic model in Alaska requires activities that support the State's goals of improved member outcomes and population health, reduced cost, and increased member and provider satisfaction. We will accomplish these goals by implementing the MCO model, which includes, integrated care, more accessible services, new modes of member communication and education, and operational effectiveness. Each component of our MCO model includes a set of quality measures and metrics that align with the State's *Healthy Alaska 2020* targets.

Cost Effectiveness through Operational Efficiency

We align our core MCO organizational framework for primary care practices to PCMH principles: strong focus on care management, data analysis, performance measurement, continuous quality improvement and best practices. We train our member services and provider services staff members to resolve issues in the first phone call to enhance efficiency and improve member and provider satisfaction. Our provider training also reinforces correct coding for faster authorization and claims processing, resulting in increased access to care, fewer duplicated services and more efficiently processed claims. At least quarterly, we will assess our performance in meeting the cost effectiveness, improved access, improved outcomes, and improved population health outcomes and goals. If we have not met the ultimate outcomes goals for one of these variables, we will continue to introduce interventions and implement activities until we have met the goal. With each iteration of the logic model process, we will improve not only the outcome, but also the process we use to reach the desired outcome.

Improved Access through Improved Network Provider Performance

We have primary care incentive models, allowing participating providers to earn bonus incentives/payouts for improved performance in these quality measures. Bonus opportunities are based upon savings accrued against total cost of care, or clinical efficiency metrics. Our Quality Shared Savings model gives primary care practices with more than 1,000 of our members the opportunity to earn bonus payouts in addition to their FFS reimbursement for meeting or exceeding established quality measure thresholds. The program includes both upside/downside shared savings and shared deficit provisions, based upon performance against total cost-of-care metrics. Performance against these quality measures, aligned with state metrics, determines the distribution of shared savings that providers may earn. Participating providers will drive improvement in Alaska's critical health measures: adolescent

well-child visits; comprehensive diabetes care, including HbA1c testing and eye exams; follow-ups after hospitalization for mental illness; childhood immunization status; timeliness of prenatal care and frequency of postpartum care. Over the last decade, we have fostered the adoption of PCMH principles into Medicaid primary care practices. There are currently 21 PCMH-certified practices in Alaska, with nine located in our selected service boroughs — Fairbanks/North Star, Anchorage, Juneau and Mat-Su. Providers have up to 10 targeted preventive care measures to determine quality-improvement incentive payouts, for example: increasing baseline metrics for HbA1c testing by at least 5 percent; and at least 10 percent baseline increase of well-child visits for children 3 years of age or older.

Improved Outcomes through Integrated Care

Our MCO model incorporates comprehensive health interventions that are person-centered and based upon an integrated, holistic approach to resolving the member's medical and BH conditions. We also coordinate ancillary services such as vision and dental services, and community supports, as needed. Our Whole Person Care model enables our care teams to monitor each member's health status proactively so they can respond to data indicating a need, take action to meet that need, and prevent an escalation of the member's utilization. We reduce inappropriate ER use through improved access to primary care and BH services, provide members with ER alternatives, offer RNs who can provide triage, and engage members after ER visits to reduce future inappropriate ER use. Then, we assess the overall improved outcomes and effectiveness of the program using quality and utilization metrics (e.g., HEDIS).

Improvements in Population Health by Meeting Ultimate Outcome Goals

We will use the logic model to identify intermediate and ultimate outcomes and assess our progress toward overall population health outcomes, including increased preventive/planned care, and lower chronic disease and mortality rates. As we introduce interventions and activities, we work toward expected outputs and outcomes. If those outputs and outcomes do not align with the ultimate population health goals, we will repeat the process of introducing interventions and activities, with specific attention to corrective actions that will help us meet the ultimate population health outcomes. As we improve member access to quality care and improve member and provider education, we can improve health outcomes and as a result, overall population health.

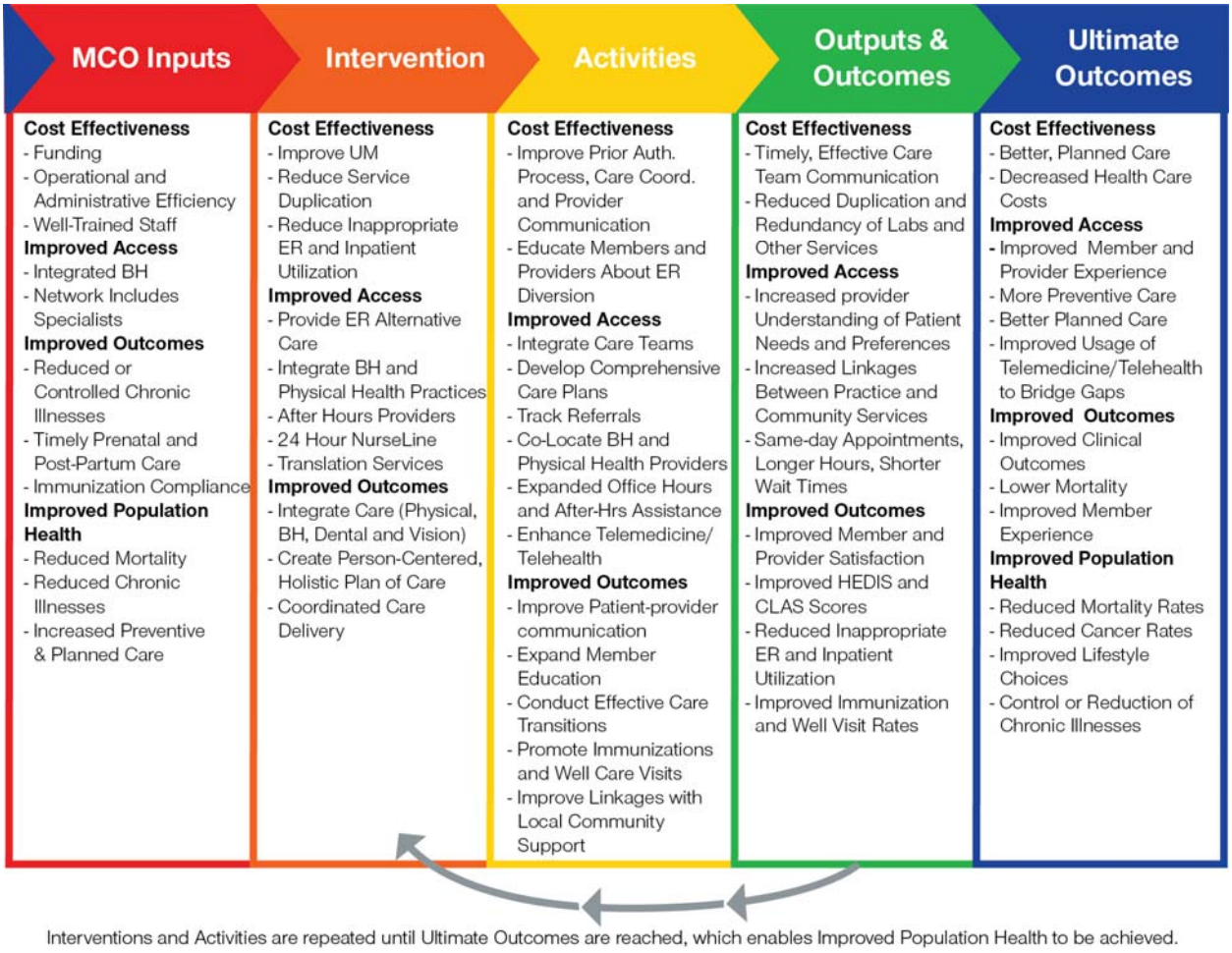

Figure 12. A Logic Model identifies intermediate and ultimate outcomes of interventions and the pathways through interventions and activities to produce ultimate outcomes.

2) A list of the evaluation questions

We use the following questions to assess our MCO model's progress toward meeting the Department's goals. We evaluate improvements in access to care, health outcomes, cost savings and population health.

- ***Improved Access:*** Has our MCO model achieved improved access to quality, culturally competent care in the most appropriate setting, resulting in reduced inappropriate ER and inpatient utilization?
- ***Improved Health Outcomes:*** Has our MCO model improved individual member health outcomes, including the ability to move to a lower level of care, reduce or eliminate pharmaceutical supports, and maintain a healthier lifestyle, as validated by claims data?
- ***Cost Savings:*** Has our MCO model achieved operational first-year cost neutrality, and is it aligned to achieve operational cost savings for the State thereafter?
- ***Population Health:*** Has our MCO model moved our covered members toward improved population health, with a focus on meeting the 25 priorities outlined in *Healthy Alaskans 2020,* as indicated by reduced mortality and cancer rates, fewer newly diagnosed diabetic members, and an improved rate of immunizations and well-care visits?

3) A description of the qualitative and quantitative data that will be used in the evaluation.

The ***qualitative data*** we will collect and use to evaluate the performance and success of the project includes member and provider-satisfaction anecdotal feedback, advisory committee feedback, and complaints and grievances. The ***quantitative data*** we collect includes HEDIS and CAHPS results, reduced health care delivery costs, and improved health outcomes. We will use this quantitative data to assess our progress in collaborating with the State in moving the population toward meeting the top 25 leading health Indicators in the Healthy Alaska 2020 initiative.

4) A description of the data sources and data collection and analysis methods that will be used. Include a discussion of the type of staff resources who will be assigned to conduct the evaluation.

Our health information technology systems collect, analyze, integrate and report data across all of our operational and administrative functions. For the CCDP, these systems enable us to generate required and ad hoc reports and compliance scorecards, as well as a robust performance dashboard according to the State's reporting and performance-monitoring requirements. Our reporting solution integrates medical, behavioral, pharmacy, financial, demographic and socioeconomic data to produce information and analytics needed to assess our program offerings effectiveness, insure operational efficiencies, meet our state partner's expectations, and manage utilization and medical outcomes.

Data Collection and Analysis Methods

We use a number of data collection and analytical methods to conduct qualitative and quantitative population health analyses and assess our performance in meeting the State's goals. Using MedMeasures, our NCQA-approved database, we monitor and track data to support automated data collection and analysis, including expected versus actual results, to identify trends and early opportunities for intervention. Using this analysis, we can make rapid strategic decisions through a Plan-Do-Study-Act (PDSA) cycle, to achieve performance goals as quickly as possible.

Data Collection and Sources

Throughout the contract, we will use our Universal Tracking Database (UTD) application to track gaps in care data for members and their entire family through one phone call. Depending upon the type of provider group, we collect HEDIS data that is distributed and reviewed monthly/quarterly via provider advocates (for our Accountable Care Communities) or clinical practice consultants (CPCs). We also collect CAHPS data to assess member and provider satisfaction, claims data to assess inappropriate ER and inpatient admissions, member-pharmacy prescription history to assess multiple and inappropriate prescription requests, and complaints and grievances that repeatedly involve the same providers or facilities. Our information sources are provider self-reported data; medical, BH and pharmacy claims data; and financial, demographic and socioeconomic data. Using our robust analytical and data warehouse tools, we monitor and review provider quality performance. Examples of our data sources include:

- CommunityCare
- SMART data warehouse (aggregator database for all claims, member, provider, pharmacy, vision, dental files, state history files and IRIS immunization registry files)
- MedCapture NCQA Certified HEDIS software
- Healthplan Manager Application (provides on-demand analysis of medical claims data combined with population demographics, geographic and economic data)

- Comparative Market Analysis & Reporting Tool (CMART) (centralized enterprise reporting for HEDIS and CAHPS)
- Impact Pro

Data Analysis

Once compiled, our data analytics and health care economics team uses this data to conduct monthly and quarterly aggregate and provider/member level performance reporting based upon quality and targeted criteria. This analysis identifies members with gaps in care and stratifies the membership for a variety of intervention efforts that reward members for completing care milestones. HEDIS measure data is critical to our efforts to reimagine health care through engagement with our providers. Analysis of this data provides a snapshot of aggregate rates relative to minimum performance standards, peers and provider-incentive agreement standards (when established), gaps in care data for members assigned to the practice, and relevant utilization patterns for each of these members. Our member-level data collection and analysis system produces a monthly status report for targeted measures.

Staff Assigned to Conduct the Evaluation

Our operational Alaska-based compliance office works with our performance excellence manager and senior plan leadership to create a contractual roadmap to identify and record each required program component. This tool offers a roadmap to assign accountable owners who will assess status and risk, identify appropriate metric(s) and establish reporting timetable. Accountable owners include employees of our Alaska CCDP health plan, assigned as needed for each status and risk assessment, as well as national subject matter experts. To assist in data collection and analysis, our national business intelligence (BI) reporting team will support our Alaska CCDP health plan by providing standard, scheduled, customized and/or ad hoc reports. This team consists of over 100 staff that manages our robust, integrated reporting and data analytics solution.

5) A plan for on-going performance measurement and monitoring.

Our plan for ongoing performance measurement and monitoring begins with a clear assessment and understanding of our contractual performance requirements. The performance excellence manager and functional area staff monitor their assigned performance against our contractual and internal performance metrics. When performance in any functional area does not meet required levels, the accountable owner within that functional area develops a remediation plan and submits the plan to leadership for review and approval. The functional areas and health plan leadership review and make recommendations through our Joint Operating Committee (JOC), which meets quarterly and more often as necessary to address performance issues. The quality department provides ongoing monitoring and review of program performance through our quality committee structure, led by our Quality Management Committee (QMC). Subcommittees of the QMC provide oversight of the complaints and appeals resolution process. The quality department also receives monthly HEDIS interim performance reports that enable us to guide our work throughout the year to achieve improvement goals. Through these updates, we verify that the health plan is closing care gaps, educating and engaging providers and members, and achieving the Department performance goals.

6) A timeline for the evaluation and performance monitoring system.

Our CCDP evaluation and performance monitoring system will follow our standard review and reporting timeline, as specified in the contract. We will assess data and submit findings monthly quarterly or annually, as required, to meet each of the specific contractual reporting requirements. As the logic model represents the workflow for the overall programmatic design, this methodology and timeline is the most applicable.

4.02.06 Experience, Qualifications, and Financial Requirements (10 page maximum; financial statements and other required forms and certifications are not included in the page limit)

A. Experience and Qualifications

1) Describe the offeror's (and collaborative entities' if applicable), experience providing services similar to those proposed. Indicate number of years of operations, and the state(s) and/or Alaskan communities in which the entity has operated.

UnitedHealthcare is one of the nation's leading Medicaid MCOs, with more than 35 years of Medicaid and public sector experience. We have extensive contract experience in Alaska, providing health care services for more than 121,000 military and veteran, Medicare, and commercial and government employee members. We have been serving TRICARE members for four years, and serving our Medicare members since 2006. We also provide managed care services to more than 5.9 million low income and medically fragile members in 24 states, including Arizona, Colorado, Delaware, Florida, Hawaii, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Nebraska, Nevada, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Washington and Wisconsin. We are currently implementing contracts in Missouri and Virginia, which will go-live in 2017.

- ***Children's Health Insurance Program (CHIP):*** We provide CHIP services to 231,000 members who are not covered by commercial insurance or by Medicaid, in 22 states.
- ***Childless Adults & Programs for the Uninsured:*** We provide services for over 1,192,000 members, in 16 states, for both Family Health Plus and Medicaid Expansion; these programs are developed by states with state or federal funds for adults and families.
- ***Integrated Physical Health (PH)/Behavioral Health (BH):*** We serve more than 4.9 million members in the 22 states plus the District of Columbia, where we provide integrated physical health and BH, including Arizona, Delaware, Florida, Georgia, Hawaii, Iowa, Kansas, Louisiana, Massachusetts, Michigan, Mississippi, Nebraska, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Washington and Wisconsin.
- ***Integrated Physical Health and Prescription Drug Benefits:*** We provide integrated pharmacy benefits for 3.8 million members in Delaware, Florida, Hawaii, Iowa, Kansas, Louisiana, Massachusetts, Mississippi, Nebraska, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Texas and Washington.
- ***Long-Term Services and Supports (LTSS):*** We provide LTSS service to 317,000 members in 14 states, supporting individuals residing in a nursing home or receiving HCBS in the community and participating in other LTSS programs. We also have Medicare-Medicaid (MMP) programs in two states, representing 26,000 members.
- ***Temporary Assistance to Needy Families (TANF):*** We provide TANF services to more than 3.7 million members in 23 states, to serve primarily young women and children, programs for families and children with high-prevalence and debilitating chronic illnesses such as cardiovascular disease, asthma, diabetes, HIV/AIDS and high-risk pregnancies.

2) Describe organizational licenses and certifications that would be required to deliver services under the proposed model. Provide evidence of current relevant licenses and certifications, and provide a plan with timeline for obtaining new licenses and certifications that would be required if the proposed project is awarded a contract under this RFP. Note that this response should align with the information provided in the Gantt chart required under Section 4.02.05.

We have the organizational licenses and certifications that are required to deliver services under the proposed model. Attachment 4.02.06.A.2-1 – Evidence of Current Relevant Licenses and Certifications includes these licenses and certifications.

3) Provide references with contact names and phone numbers for similar projects the offeror's firm has implemented or similar services the firm has delivered within the past five years.

We are providing the following references, for projects we have implemented over the last five years, with contact names and phone number.

State	Contact	Title/Name of Service/Contract
Arizona	Meggan Harley Chief Procurement Officer AHCCCS 701 E. Jefferson, MD5700 Phoenix, AZ 85034 (602) 417-4538	Acute Care/Uninsured Children Origination: 1982 Current Contract: Oct. 1, 2013 – Sept. 30, 2018
Nevada	Marta Jensen Acting Administrator DHCFP 1100 E. William St., Suite 102 Carson City, NV 89701 Marta.Jenson@dhcfp.nv.gov	Acute Care/Uninsured Children Origination: 1997 Current Contract: July 1, 2017 – June 30, 2022
Washington	MaryAnne Lindeblad State Medicaid Director Health Care Authority Cherry Street Plaza 628 8th Avenue SE Olympia, WA 98504	Healthy Options – Washington Apple Health Origination: 2012 Current Contract: Jan. 1, 2017 – Dec. 31, 2017

4) Provide an organizational chart specific to the personnel assigned to accomplish the work required for the proposed project; illustrate lines of authority; designate the individual responsible and accountable for the completion of each component and deliverable of the RFP.

Our CCDP Organizational Chart

The organizational chart we provide herein aligns with the goals and expectations described throughout this RFP. In new Medicaid markets, like Alaska, we assign qualified and experienced individuals from our national team as interim leaders during the contracting and implementation phases while our human capital team recruits local candidates to fill any open positions. This approach enables the implementation and staffing plans to be activated and completed on time and within budget.

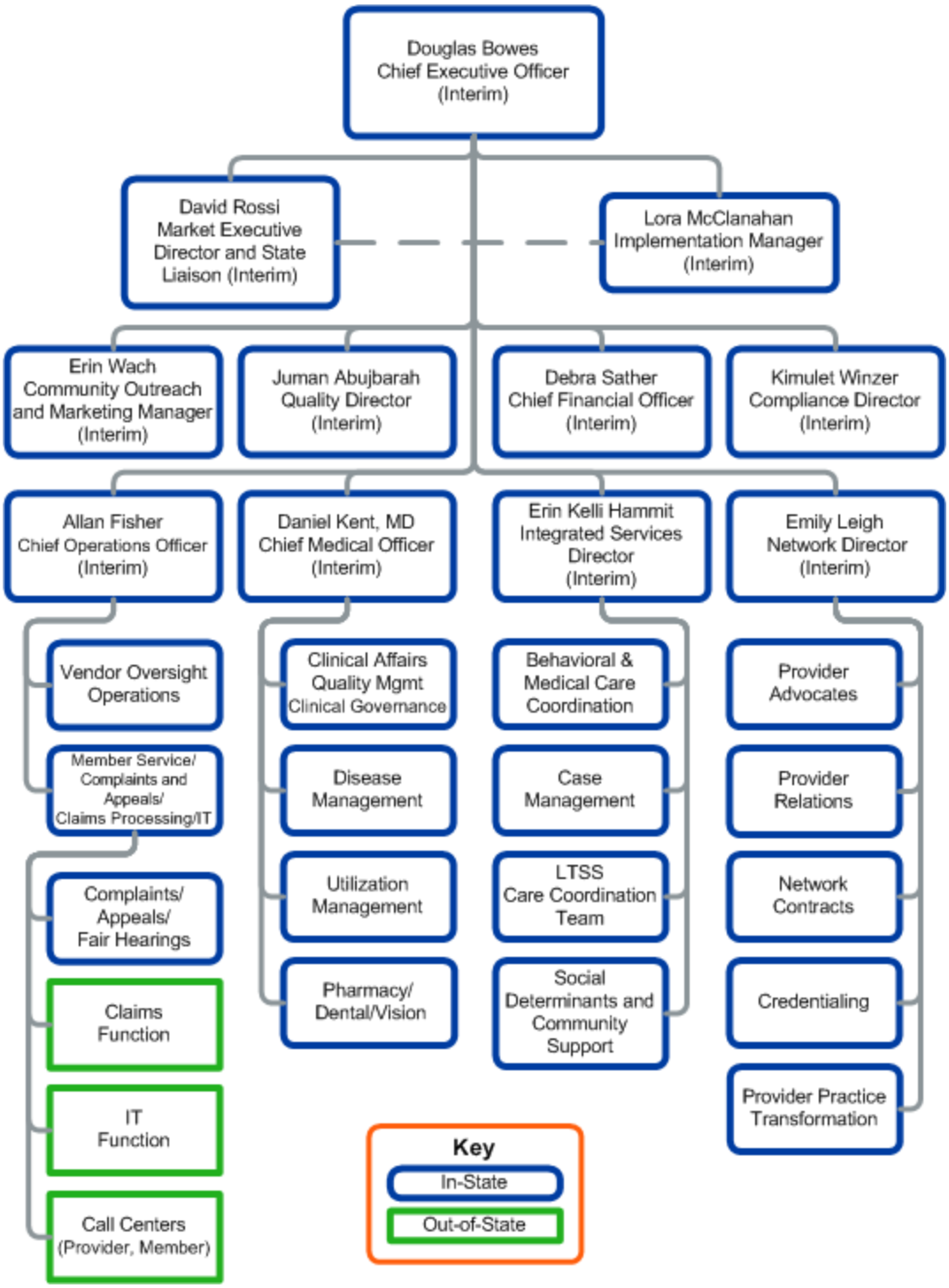

Figure 13. Our organizational chart shows the personnel assigned to accomplish the work required for this CCDP program.

5) Provide a narrative description of the organization of the project team and a key personnel roster that identifies each person who will work on the proposed project and provide the following information about each person listed:

- Title
- Resume
- Location where work will be performed
- Estimated number of hours and cost

Resumes of the individuals listed in our key personnel roster are provided as Attachment 4.02.06.A.5 – Key Personnel Resumes.

Organization of the Health Plan Team

The organization of our health plan leadership team — consisting of our business implementation, national and local operations and local leadership teams — demonstrates our integrated approach to managing the delivery of health care services for Alaska's CCDP. The assembly of these teams supports each functional unit's ability to effectively manage day-to-day operations as we serve members, providers and the Department during and after the project launch. Our Anchorage office will be the hub for our Alaska-based health plan leaders, who will be key contacts for the Department. This team has extensive knowledge regarding the Alaska Medicaid program and will have access to resources in Medicaid medical, BH, SUD treatment and LTSS.

The local leadership team is supported by our national teams that manage high-volume or complex operations such as claims processing, data analysis, reporting and management information systems (MIS) and work in strategic locations in the United States. We are part of the same UnitedHealthcare enterprise and work together seamlessly to integrate all benefits for our members and to deliver a positive contracting, training and service experience to the local provider community.

Chief executive officer (CEO) Douglas Bowes and chief operations officer (COO) Allan Fisher will lead the highly qualified and dedicated staff of professionals we present with this proposal. This leadership team works collaboratively to align our Whole Person Care model, integrated delivery strategies, human resources, and health information technology and reimbursement policies to achieve the CCDP's objectives of better care, better health and lower costs.

Location where Work will be Performed and Estimated Hours

Our organizational chart depicts functional locations as in state or out of state. The functions located out of state are claims processing, call centers and information technology, which are high-volume, complex operational support services. Our CEO and COO are responsible for oversight of these functions and will be accountable for driving our service in these key operational areas toward perfection.

At this pre-award stage of the project, we have built our health plan team by dedicating interim team leads while our employment recruiters seek local qualified candidates. For the positions listed in the key personnel roster, we have dedicated qualified and experienced team leads, with plans to have these full-time positions filled by Sept. 15, 2017, or as required by the Department following award announcements — whichever is later — with personnel located at our Anchorage office and 100 percent dedicated to the CCDP line of business.

For the compliance and quality director positions, we have dedicated qualified and experienced team leads for the interim, and will fill these positions by Dec. 1, 2017, or as required by the Department following award announcements — whichever is later — because there will not be

active cases to manage until the program is launched. Our plans are for these positions to be located at our Anchorage office and 100 percent dedicated to the CCDP line of business.

As newly hired leaders and local staff working directly with members and providers are hired, trained and assume their posts, the interim team continues to work with the local team leaders, providing training, mentoring and coaching assistance as needed, and stays connected with the local team until the plan is operating smoothly.

The Key Personnel Roster identifies each person we have dedicated to Alaska's CCDP. Accompanying resumes for each person named as functional lead in this roster are provided in the following pages.

Key Personnel Roster

Functional Team Lead, Title	Role, Responsibilities, Estimated Hours and Work Location
Douglas Bowes **Chief Executive Officer** **(Interim)**	Accountable for implementation, administration, management and outcomes of all aspects of the CCDP contract. Accountable for making sure resources align with contract requirements, member needs and delivery capabilities to ensure quality service to members and providers. Hours and Location: ***Full-time position in Alaska***
David Rossi **Market Executive Director & State Liaison** **(Interim)**	State liaison and key contact responsible for market readiness with focus on resource and personnel allocation that enables timely operations setup, readiness and activation. Directs the strategic development, growth and operations of the new health plan in providing innovative care to CCDP members. Overall responsibility: provide executive oversight and leadership before, during and after program launch to meet the Department's needs and achieve contractual, state and federal regulatory compliance. Hours and Location: ***Full-time position***
Lora McClanahan **Implementation Manager** **(Interim)**	The dedicated implementation program lead responsible for working closely with the CEO and market executive director and the Alaska-based leadership team on all aspects of the Alaska CCDP implementation. Collaborates with market executive director regarding communication with State stakeholders and the Department to make sure we provide an updated work plan on a monthly basis. Responsible for leading the strategic and tactical implementation of all activities related to health plan operations setup, including backroom functions that support all functional areas within our Alaska health plan. Hours: ***Fully dedicated to CCDP implementation project through 120 days post-go-live*** Location: ***A combination of on- and off-site as needed for the duration of the implementation project***
Allan Fisher **Chief Operations Officer** **(Interim)**	Responsible for the overall integration of the operations team and makes sure each functional area addresses the whole person care needs of our members and providers along the entire health care continuum, including oversight of Alaska eHealth Network. Oversees IT functions regarding enrollment, network adequacy and contracting, benefit and contract setup, claims processing timeliness and accuracy, encounter data completeness and accuracy, member and provider call center operations, local accountability for health and resource allocation, and oversight of subcontractor delegation. Hours and Location: ***Full-time position in Alaska***

Functional Team Lead, Title	Role, Responsibilities, Estimated Hours and Work Location
Daniel Kent, M.D. **Chief Medical Officer** **(Interim)**	Responsible for overall clinical affairs and governance, clinical consulting, pharmacy, dental, clinical operations and clinical quality. Responsible for provider quality and outcomes. Supports relationship with Alaska chief medical officer and clinical leaders. Provides medical oversight, expertise, leadership and direction for the administration of the CCDP's provision of health services. Is actively involved in all major clinical and quality management (QM) components of UnitedHealthcare's operations. Oversees clinical operations initiatives that focus on clinical excellence, affordability and performance improvement. Responsible for developing and implementing utilization management, disease management, and QM strategies to serve CCDP members. Hours and Location: ***Full-time position in Alaska***
Erin Kelli Hammit **Integrated Services Director** **(Interim)**	Responsible for our whole person care approach capability to facilitate addressing social determinants of health. Coordinates efforts regarding BH services, such as SUD programs and initiatives to improve outcomes. Oversees the operations of the BH clinical program for the CCDP, including UM, field care management and advises our leadership team about BH issues specific to Alaska. Oversees the integrated delivery of physical and BH, LTSS, ancillary and social determinants services. Hours and Location: ***Full-time position in Alaska***
Debra Sather **Chief Financial Officer** **(Interim)**	Responsible for financial-related functions including audit, internal control, accounting, financial analysis, budgeting, revenue management, and medical cost analysis, financial reporting, and administrative efficiency to meet the CCDP goals of financial compliance and improving financial sustainability of the system. Hours and Location: ***Full-time position in Alaska***
Kimulet Winzer **Compliance Director** **(Interim)**	Responsible for the health plan's overall compliance with the Contract. Responsible for and oversees program integrity and compliance-related functions covering the integrated services such as compliance with State and federal rules and regulations, preventing and detecting fraud, coordinating with the special investigation unit and communicating with the CCDP's Program Integrity and Fraud, Waste and Abuse Unit of the Attorney General's Office. Coordinates implementation of Contract requirements, tracking and submission of Contract deliverables and coordination of audits. Hours and Location: ***Full-time position in Alaska***
Juman Abujbarah **Quality Director** **(Interim)**	Responsible for the development, implementation and oversight of the day-to-day operations of the QM department to verify compliance with all regulatory and accreditations requirements. Provides leadership and oversight of complaints, grievances, appeals and fair hearings. Oversees continuous quality improvement processes, including process reviews and an annual evaluation of the entire QM program. During implementation, establishes the QM program structure and plans. Ongoing operations include program committee reviews, quality of care management and continuously improving quality scores. Hours and Location: ***Full-time position in Alaska***
Emily Leigh **Network Director** **(Interim)**	Responsible for leading strategic and tactical implementation of activities related to network development and adequacy, community outreach and maintenance of our service delivery system. Collaborates with network and community providers, provider associations and material subcontractors to promote the health and well-being of plan members by providing access to quality, cost-effective health services. Hours and Location: ***Full-time position in Alaska***

Functional Team Lead, Title	Role, Responsibilities, Estimated Hours and Work Location
Erin Wach **Community Outreach and Marketing Manager (Interim)**	Responsible for the community outreach and marketing team. Facilitates our attendance at community events and works with community leader and advocacy groups. Supports health services delivery and member services to offer current, actionable information regarding community resources that address the psychosocial needs of our members, thereby facilitating the delivery of whole person care. Hours and Location: ***Full-time position in Alaska***

Estimated Workforce Costs

We provide an estimate of overall staffing costs in our Pro Forma statement as Attachment 4.02.07.B –- Pro Forma. Because we are proposing an MCO model rather than an individual project model, staffing hours will not be assigned as they would with other models or consulting projects with a limited lifespan. An estimate of the direct workforce costs tied to the key personnel and their direct reports will range from $5.6 to $6.1 million annually for 2018 through 2020 for an estimated total of $17.5 million over the three-year period. We will be able to provide greater detail of direct workforce costs during contract negotiations with the Department, when more detail about staffing requirements will be available.

B. Financial Stability, Capital Reserve and Solvency Requirements

For the lead entity of the proposed demonstration project, and for other collaborating entities if applicable and relevant, provide the following documentation:

1) The 2013, 2014, and 2015 independently audited annual financial statements, and associated enrollment counts if applicable. Audited statements should be prepared under U.S. generally accepted accounting principles; and audited under U.S. generally accepted auditing standards.

UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company is the respondent. Please see the following associated audited financial statements, for the past three years 2013, 2014 and 2015, in the following attachments:

- Attachment 4.02.06.B.1-1 – Audited Financial Statement UnitedHealthcare Insurance Company 2013
- Attachments 4.02.06.B.1-2a-b – Audited Financial Statement UnitedHealthcare Insurance Company 2014
- Attachment 4.02.06.B.1-3 – Audited Financial Statement UnitedHealthcare Insurance Company 2015

UHIC Holdings, Inc.

UHIC Holdings, Inc., a holding company, is the 100 percent owner of UnitedHealthcare Insurance Company. UHIC Holdings, Inc. does not have operations other than ownership of subsidiaries or financial statements.

United HealthCare Services, Inc.

United HealthCare Services, Inc. owns 100 percent of UHIC Holdings, Inc.

UnitedHealth Group Incorporated

UnitedHealth Group Incorporated (UnitedHealth Group) owns 100 percent of United Healthcare Services, Inc. The following diagram

Figure 14. The parent/child relationship between UnitedHealth Group Incorporated and UnitedHealthcare Insurance Company.

illustrates the relationship between the respondent UnitedHealthcare Insurance Company, and UnitedHealth Group, Incorporated, the parent company.

2) The four most recent quarters of quarterly financial statements, with year-to-date financials, including cash flows and explanation of cash flows. Provide supporting documentation, such as copies of bank statements. In excel format, provide the following for each of the financial statements provided:

i. working capital

ii. current ratio

iii. quick ratio

iv. net worth

v. debt-to-worth ratio

We have provided the four most recent quarters of quarterly financial statements, with year-to-date financials, including cash flows and explanation of cash flows and supporting documentation.

- Attachment 4.02.06.B.2-1 – UnitedHealthcare Insurance Company Q3 2015 Filing Uniform Format
- Attachment 4.02.06.B.2-2 – UnitedHealthcare Insurance Company Q1 2016 Filing Uniform Format
- Attachment 4.02.06.B.2-3 – UnitedHealthcare Insurance Company Q2 2016 Filing Uniform Format
- Attachment 4.02.06.B.2-4 – UnitedHealthcare Insurance Company Q3 2016 Filing Uniform Format

Financial Ratios: We are providing the requested quarterly financial ratios and data for UnitedHealth Group because UnitedHealthcare Insurance Company does not classify its balance sheet into current and long-term assets or liabilities. UnitedHealthcare Insurance Company also has no debt, which negates the following debt calculations. Therefore, this portion of the response only applies to UnitedHealth Group.

SECONDARY UNITEDHEALTH GROUP QUARTERLY FINANCIAL DATA

Selected Financial Data from the Four Most-Recent Quarterly Financial Statements ($ in millions)				
Quarter Ended	**Sept. 30, 2015**	**March 31, 2016**	**June 30, 2016**	**Sept. 3, 2016**
Working Capital(1)	($10,018)	($12,540)	($14,078)	($15,328)
Current Ratio(1)	0.749	0.729	0.703	0.700
Quick Ratio(1)	0.609	0.598	0.584	0.597
Net Worth	34,693	36,891	38,031	39,491
Debt-to-Worth Ratio(2)	2.117	2.195	2.145	2.131

Notes:
(1) UnitedHealth Group (the "Company") classifies cash and investments by maturity.
(2) In Q1 2016, the Company retrospectively adopted Accounting Standard Update 2015-03, "Interest-Imputation of Interest (Subtopic 835-30); Simplifying the Presentation of Debt Issuance Costs" (ASU 2015-03) as required. Accordingly, the Company reclassified $131M in debt issuance costs that were recorded in other assets on the Consolidated Balance Sheet as of Sept. 30, 2015, to long-term debt, less current maturities.

Formula Definitions: The following definitions apply to the calculations in the table:

- ***Working Capital:*** Current assets - current liabilities
- ***Current Ratio:*** Current assets/current liabilities

- ***Quick Ratio:*** (Cash + cash equivalents + short-term investments + current receivables)/current liabilities
- ***Net Worth:*** Total assets - total liabilities
- ***Debt-to-Worth Ratio:*** Total liabilities/net worth

Please see Attachment 4.02.06.B.2-5 – UnitedHealth Group Financial Ratios for the Excel version of the UnitedHealth Group Financial Ratios.

3) A statement as to whether the lead entity or parent company has filed bankruptcy or insolvency proceedings within the last five years. If so, provide an explanation including relevant details regarding the proceedings and their outcomes.

Neither UnitedHealthcare Insurance Company, nor its parent organization, affiliates nor subsidiaries have filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee or assignee for the benefit of creditors.

4) If the lead entity is a publicly traded company, provide:

i. The most recent U.S. Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most recent 10-Q Quarterly report;

UnitedHealth Group, Incorporated ultimately owns 100 percent of UnitedHealthcare Insurance Company. UnitedHealth Group, Incorporated is a widely held, publicly traded company, with no individual or parent having more than a 5 percent stake as indicated in the RFP. Please see our most recent U.S. SEC Form 10K Annual Report, and the most recent 10-Q Quarterly report in Attachment 4.02.06 B.4.i – Financial Statements.

- 4.02.06.B.4.i-1 – Form 10-K UnitedHealth Group 2016
- 4.02.06.B.4.i-2 – Form 10-Q3 UnitedHealth Group 2016

ii. A statement regarding whether there have been any SEC investigations of the company within the last five years. If so, please provide an explanation including relevant details regarding the investigation and their outcomes; and,

UnitedHealthcare Insurance Company is not aware of the SEC conducting any investigations concerning it or its parent organization, affiliates or subsidiaries within the past five years.

iii. The company bond rating for the last three years.

UnitedHealth Group's bond ratings over the last three years illustrate our financial stability.

UNITEDHEALTH GROUP SENIOR UNSECURED DEBT RATING

Bond Rating Organization	2016	2015	2014
Moody's Effective Date	**A3** 7/21/2011	**A3** 7/21/2011	**A3** 7/21/2011
Standard and Poor's Effective Date	**A+** 11/3/2014	**A+** 11/3/2014	**A+** 11/3/2014
Fitch Ratings Effective Date	**A-** 1/30/2008	**A-** 1/30/2008	**A-** 1/30/2008
A.M. Best Effective Date	**bbb+** 1/29/2008	**bbb+** 1/29/2008	**bbb+** 1/29/2008

5) If the lead entity is a privately owned company, provide the company's credit rating for the last three years.

Not applicable. UnitedHealthcare Insurance Company is part of a publicly held company.

4.03.06 Experience, Qualifications, and Financial Requirements (5 page maximum for additional information)

6) Provide three statements containing Risk Based Capital Ratio as prepared in accordance with instructions published by the National Association of Insurance Commissioners (NAIC).2 Include for both the proposing entity and the parent organization if applicable.

We have interpreted the request for three statements to reference annual reports for the last three years. Therefore, our Risk Based Capital (RBC) Ratio statements for 2013 – 2015 can be found in Attachments 4.03.06.6-1a-3b, Risk Based Capital Ratio Statements.

UnitedHealth Group, as the parent company, does not file Statutory Filings requiring RBC Ratio statements. However, the Requested RBC Ratio statements represent UnitedHealthcare, the legal entity on which the business will reside. The UnitedHealthcare consolidated RBCs for 2013 – 2015 are as follows:

- In 2013, the RBC Ratio was 256 percent.
- In 2014, the RBC Ratio was 247 percent.
- In 2015, the RBC Ratio was 231 percent.

7) Describe the process and plan with timeline for obtaining the required insurance certifications required under Alaska state insurance law.

We have an active MCO license and do not require additional insurance certifications under Alaska state insurance law.

4.02.07 Financial Projections and Potential for Cost Containment or Savings (10 page maximum; financial tables and spreadsheets are not included in the page limit)

As noted in Section 1.02 of this RFP, the Department's intent is to collaborate on projects for which new or reformed services and/or payment models can be reimbursed as a covered Medicaid service, not as an administrative fee. It is also the Department's objective to collaborate on projects that are most likely to be budget neutral to the State in the first year, and achieve State savings in subsequent years.

A. Describe how the proposed project will lead to cost containment or savings for the State Medicaid program. Describe the anticipated areas of savings including target populations and subpopulation(s) and the initiatives that will be used to drive savings.

We are proposing an MCO model to encompass new services and payment models that are reimbursed as covered Medicaid services rather than as administrative fees. We believe that Alaskans should have improved access to quality, integrated health care that is budget neutral to the State in the first year, and will achieve savings for the State in subsequent years. We will collaborate with the Department to reach this goal through increased access, whole-person community health systems, and supportive population health initiatives. Our MCO model encompasses more than just health care delivery. Our model employs the Quadruple Aim philosophy as it addresses the *Healthy Alaskans 2020* leading health priorities and meets the Department's cost-containment objectives. In 2007, the Institute for Healthcare Improvement (IHI) developed the Triple Aim model. Its three dimensions focus on improving the patient experience, including quality and satisfaction; improving population health; and reducing the per-capita cost of health care. Expanding on this model, we adopted the Quadruple Aim concept that adds provider satisfaction, a necessary component for an inclusive network that offers improved access to quality care, while reducing the per-capita cost. Our collaborative network provider relationships enable us to address bottlenecks that reduce access and drive costs proactively.

Interventions to Lower Utilization and Move to Appropriate Care

We take a hierarchy-of-needs approach to care delivery, recognizing that social determinants are a significant driver of a member's health. Members with high utilization and high costs often face numerous challenges, and our experience shows even the best interventions may be ineffective unless we first address the individual's fundamental needs, such as housing. Using assessment results and through care planning, we connect members to community resources and provide face-to-face resources that remove barriers to care so that the member's health care needs become the focus. Through our Whole Person Care model, we identify members with persistent high utilization and implement timely, targeted interventions to help manage the health concerns that are leading to the persistent high utilization. In addition to the core elements of our model, our approach focuses on PCP awareness of the member's identification as a very high utilizer, and engages the provider in mitigating ongoing ER and inpatient utilization. We collaborate with the provider to improve the member's health outcomes, while supporting a member's BH needs. Our approach has led to the appropriate use of health care services and improved health outcomes for these members. For the first six months of 2016, across 14 state Medicaid markets, our focus on members with persistent utilization resulted in 1,997 avoided admissions for a savings of $24.6 million; 246 avoided ER visits for a savings of $500,000; and savings of more than $25 million or $91 PMPM and $5.16 million redirecting members to their PCP instead of the ER or hospital.

Identifying Members with Emerging Risk

To best serve the needs of Alaskans, we will implement our person-centered, holistic, recovery-oriented **Whole Person Care model** that focuses on identifying members with emerging risk and high risk, and looks for members with health behaviors and health care utilization that are impactable. Our model encompasses a whole-person view that prioritizes an understanding of how the member's physical, behavioral, functional, social and cultural circumstances are interconnected and need to be addressed to maintain health. It engages resources, services and supports to help members meet their needs and achieve their goals and desired outcomes. Each month, we risk stratify our membership to identify members who can benefit from care coordination. Our algorithm-based blended identification and stratification process helps us understand the characteristics, needs and social, BH, medical and functional circumstances of the entire group of members we serve. Our process integrates medical, BH and pharmacy claims and lab test results, and other data. We use Impact Pro, our predictive modeling tool, to analyze gender, age, other demographic variables, future inpatient risk, prior-year total cost of care spending, acute inpatient admissions, ER visits, pharmacy, BH and total chronic conditions. Our analysis delivers a prospective risk assessment for every member and identifies the clinical and utilization events affecting a member's health risk to identify members that may benefit from care coordination. We identify members who can benefit from care coordination using proprietary risk stratification criteria. **High risk** members have the highest total cost of care. Specific claims drill-downs are predictive of high utilization from year-to-year. We generate a risk score for each member and stratify the member according to cost. These members are likely to be in the top 2 percent of health care costs in the next 12 months and are likely to continue to experience this utilization from year-to-year. **Emerging risk** members are those who, without intervention, would likely be high utilizers in the coming year. They have risk factors, such as multiple medications, a BH medication with no BH provider, more than six BH or medical providers, and social determinants. These members with impactable opportunities are likely to be in the top 15 percent of health care costs in the next 12 months without intervention.

As we discussed in our response to RFP Section 4.02.03.C.1, our Whole Person Care model enables our care teams to monitor each member's health status proactively so they can respond to data indicating a need and take action to meet the need and prevent an escalation of the member's utilization. The team detects acute events, such as a hospitalization, that may require a specific intervention, a comprehensive reassessment, a care plan update or a change in their risk level. Leading quality indicators in our Medicaid and D-SNP programs suggest our model is leading to improvements in key measures. In 2015, we implemented our model in the following Medicaid programs, which led to year-over-year reductions in acute inpatient admissions compared to 2014. In Kansas, we saw a 31 percent reduction; in Maryland, a 12 percent reduction; and in Florida, a 24.4 percent reduction. Building on the key elements of whole person care, our approach to managing unnecessary ER utilization is not limited to engaging members after they visit the ER. It comprises several elements, such as improving access to primary care and BH services, providing members with information about ER alternatives, providing access to RNs that can help reduce inappropriate ER use and engaging members after they visit the ER to reduce future inappropriate ER use. We measure the overall effectiveness of our efforts using quality and utilization metrics (e.g., HEDIS). We monitor quality and utilization metrics by region and targeted populations by working closely with our providers. In 2015, we saw a national decline of 3.1 percent in total ER visits. We use the term Accountable Care Community *(*ACC) to describe our collaborative partnerships with hospitals, CMHCs, FQHCs, RHCs, CHCs, PCPs and specialists across the continuum of care, with one or more primary care practices linked to one or more hospitals in a local community — in essence, a virtual accountable care organization (ACO). We find that success comes from building strong

local community partnerships and supporting practices with structure, process and outcomes to improve population health. This partnership will be visible through transformational work at a community level, by **building ACCs**. As practices become accountable for meeting the majority of their patients' physical and BH care needs — focusing on prevention and wellness, acute and chronic care — we help to transform practices from a place where care is given to a model that changes the delivery of primary health care. Our experience led to a realization that to achieve lower costs of care and improve quality, we needed to help the primary care team collaborate and connect with other clinicians serving their patients in the same community — the hospitals and specialists who also serve their patients. We launched our ACC strategy with the aim of leading health system transformation and payment transformation across the continuum of care at the community level, with primary care practices at the heart of each community.

We offer a broad and integrated, person-centered care model that emphasizes the individual person and is customized to improve the member's physical and BH. Our clinical and member services staff focus on wellness and the delivery of fully integrated physical and BH services, incorporating needed social supports for whole person care. We are committed to working with local partners who focus on serving people in the community, employing technology and support to improve efficiency, quality outcomes and overall population health. We empower each individual to realize his/her health improvement goals through a focus on recovery, wellness, literacy and personal responsibility. Our fully integrated MCO model improves the member's overall well-being and his/her quality of life through integrated physical health, BH, transportation, dental, pharmacy and vision benefits. We also have implemented a proactive approach to help members improve their ability to manage specific conditions. Through disease management (DM) education and an array of programs, we use various modalities to engage and support the member as he/she takes responsibility for his/her health. Our health promotion programs educate members about health conditions, provide health and wellness information and healthy lifestyle tips. We give members tools that foster personal responsibility and promote healthy lifestyles, such as e-books on the member portal that foster self-advocacy. As we discussed in detail in our response to RFP Section 4.02.03.A, some examples of programs we will bring to Alaskans include:

- ***The Quit For Life® Program*** is the nation's leading phone-based tobacco cessation program. It employs an evidence-based combination of physical, psychological and behavioral strategies to enable participants to take responsibility for, and to overcome their addiction to tobacco use. Using an integrated mix of medication support, phone-based cognitive behavioral coaching and Web-based learning and support tools, the Quit For Life Program produces an average quit rate of 25.6 percent[1] for a Medicaid population and an 88 percent member satisfaction rate.
- ***MyHealthLine*** uses the Lifeline free smartphone to allow our members to access the Well pass Mobile App, deliver targeted text campaigns and provide free calls to our Advocate4Me member services center and secure texting with the care team.
- ***NurseLine*** provides live telephonic access to RNs who educate members about their conditions and help them access appropriate resources. The NurseLine Audio Health Adviser™ provides recorded health information across more than 20 categories.

[1] Alere Health data on file. Book of business survey results. Results measured among respondents to a survey at six months post program enrollment, with all respondents having completed at least one Program Call.

- ***Advocate4Me*** member services advocates help members find providers or alternatives to the ER and can warm transfer members to resources that will help them access medical, health and wellness information, such as NurseLine.
- ***Health4Me*** is a free mobile app that provides secure access to health and wellness information 24 hours a day, seven days a week.

Core to our model is sustained direct engagement with members through an integrated care team, with an RN care manager, a licensed BH care manager and a community health worker (CHW). The team collaborates to implement services and supports using the right expertise and an intensity of engagement that meets the member's needs (e.g., the licensed BH care manager leads the effort to coordinate care for a member with primarily BH needs). A flexible approach to care coordination allows us to monitor the health of a larger volume of members and customize interventions to each member's needs. CommunityCare facilitates the delivery of person-centered care coordination by implementing technologies that share the member's care plan and provide the care team and the IDT with real-time, actionable information and the tools to monitor each member's progress toward achieving his/her goals, ensure he/she is experiencing improved health outcomes and monitor for acute events. The member and his/her support system/family, to whom the member agrees to consent access, also can use CommunityCare as active participants in the IDT.

Our value-based payment (VBP) provider incentives are beyond the standard Medicaid FFS reimbursement. It may include compensation for closing gaps in care, payments tied to clinical integration activities, episode-based payments, shared savings/risk and capitation/global risk. We will strategically deploy our VBP models based upon quantitative and qualitative evaluations of each provider's readiness across the reimbursement risk and clinical integration continuum. We evaluate providers we are considering for shared savings/risk models using a survey tool that assesses that provider's readiness in areas such as organizational structure, operational sophistication, cost of care and population health experience with other payers. Because providers are at varying levels of practice size and sophistication, we offer incentives that align with their willingness to enroll in an incentive plan, level of readiness and ability to meet goals, which we memorialize contractually.

In concert with this RFP submission, our national implementation and business alignment (IBA) team activates implementation work-plan tasks and builds-out the critical elements required for a successful implementation and in preparation for the on-site readiness review that we expect to take place approximately 90 days prior to go-live. Our national IBA team also will provide training for the local team, and stays with the local team as needed until the plan is fully staffed, trained and operating smoothly. For example, our provider relations team uses accessible, in-depth and tailored provider education to create seamless onboarding of new providers. They conduct both in-person and web-based training to assist hesitant providers, as well as use established educational tools and support processes dedicated to helping new providers understand managed care systems. We employ evidence-based training for members, their families and support systems.

We also offer Mental Health First Aid to PCP practices, school nurses and administrators, and others with medical backgrounds. This training promotes an understanding of signs and symptoms, as well as treatment of BH conditions, and what to do if the individual encounters someone who may have mental health issues, including SUD comorbidity. We also educate laypersons and medical practitioners about the identification of individuals who may be at risk for suicide. We will offer both Mental Health First Aid and Question, Persuade and Refer suicide prevention training in all the boroughs at least once per year. Since 2010, we have provided more than 80 Mental Health First Aid trainings nationwide. We involve local, field-based CHWs

who locate and engage our members, identify and resolve non-clinical barriers to care, and identify local resources and supports. They gather feedback to help us make systemic improvements, such as improving access to care by identifying transportation issues and reaching out to find appropriate transportation providers. Our CHWs live and work in the community and apply local knowledge and relationships with community organizations, providers and community leaders to engage our members. Key leadership staff performs ride-a-longs with field staff as an additional way of obtaining member feedback. We also engage SUD recovery coaches who help members and their support systems in a variety of ways, such as creating a change plan, linking them to local resources for harm reduction, detox, treatment, family support and education, or local support groups.

DEMONSTRATING VALUE TO THE STATE

In close partnership with the Department, our model will demonstrate value to the State through comprehensive population management, focused on achieving improved quality outcomes and cost savings by proactively addressing our members' complex needs. We achieve these goals through the development of trusting partnerships with providers to promote BH integration, reduce costs through innovative payment practices, and implement resources and tools that maximize access to quality care for our members. Our proposed model uses evidence-based guidelines for improved quality of care and efficient use of resources for our Alaska Medicaid members, including families, Denali KidCare, Medicaid Expansion, long-term care participants, individuals who are dually eligible for Medicare and Medicaid and subpopulations. We empower members by meeting them where they are to improve their health and achieve their goals. We offer a broad and integrated, person-centered care model that emphasizes the individual person and is customized to improve the member's physical BH. Our clinical and member services staff focus on wellness and the delivery of fully integrated physical and BH services, incorporating needed social supports for whole person care.

We are committed to working with local partners who focus on serving people in the community, employing technology and support to improve efficiency, quality outcomes and overall population health. We empower each individual to realize his/her health improvement goals through a focus on recovery, wellness, literacy and personal responsibility. Our fully integrated MCO model improves the member's overall well-being and his/her quality of life through integrated physical health, BH, transportation, dental, pharmacy and vision benefits. We are proposing this model in the boroughs of Anchorage and Mat-Su, Fairbanks/North Star and Juneau, as 64 percent of Alaska's population resides in these regions, and are within the CMS standards for network access. We are happy to work collaboratively with the State to expand the scope of our Medicaid model, following the demonstration project, to encompass additional areas of the state, promote increased access, and realize additional cost savings through improved health outcomes. **We believe we can achieve success within the first two years, and then work with the Department to expand the program statewide in year three.** We are one of the nation's leading Medicaid managed care plans, providing managed care services to more than 5.9 million low income and medically fragile members in 24 states. We believe we can, through expansion of this project, provide the State with additional savings, should the Department be interested in braiding other funding streams around housing and employment, thus streamlining health care and social determinants costs.

B. Provide a monthly Pro Forma financial projection for the proposed project that presents expected enrollment, revenues, and expenditures for the development phase through month 36 of operations. Describe major assumptions underlying the financial forecast.

A monthly Pro Forma financial projection for the Proposed Project is provided in Attachment 4.02.07.B – Pro Forma. The Pro Forma presents the expected administrative start-up expense

for the one-year developmental phase, prior to the start of operations in calendar year 2018. Expected enrollment, revenues and expenditures for the first 36 months of operations are presented by calendar years 2018, 2019 and 2020. There are several ***key assumptions*** underlying the Pro Forma, which we describe herein. We relied exclusively on historical claims experience provided in the Alaska Medicaid Data Book when establishing the basis for the projection. Specifically, SFY2016 was established as the base data period (dates of service from July 1, 2015, through June 30, 2016) for all populations, regions and services. It was necessary to use SFY2016 in the projection due to the Medicaid Expansion population rolled out in SFY2016. Furthermore, some populations saw significant enrollment changes between SFY2015 and SFY2016. For example, CHIP had a 20 percent increase in membership and pregnant women grew 18 percent, but the Waiver (c) Composite population decreased 6 percent over that time. It was therefore necessary to use SFY2016 to reflect the most current population and expenditure information. Additionally, we used the estimated completion factor assumptions provided by Milliman in the Alaska Medicaid Data Book to adjust the base data for incurred but not paid (IBNP) claims. The following table shows the completion factors used in the projection.

Completion Factors		
COS	**SFY2015**	**SFY2016**
Inpatient Hospital	1.009	1.133
Outpatient Hospital	1.006	1.070
Professional	1.002	1.081
ER	1.006	1.070
Pharmacy	1.000	1.005
Ancillaries	1.003	1.028
LTSS	1.003	1.027
Behavioral Health	1.006	1.063
Total	**1.004**	**1.060**

No additional base data adjustments were made for this projection. Prospective adjustments are described in the following sections. We relied exclusively on the Alaska Medicaid Data Book that was provided to develop the State Budget Projection. Reasonability checks were performed where possible, but the detailed, claim-level data from the State payment systems needed to perform an independent audit of this data was not provided. Errors in data reporting would therefore flow through to the projections.

Covered Populations: The Proposed Project applies only to the following regions: Anchorage Municipality, Matanuska-Susitna (Mat-Su) Borough, Fairbanks-North Star Borough, and Juneau City and Borough. It covers all populations and services in those regions; however, adjustments were made to the assumed membership that would be enrolled in the Project. As the American Indian/Alaska Native (AI/AN) populations are exempt from mandatory enrollment in a managed care plan, projected enrollment assumes only 3.3 percent of AI/AN enrollees will select enrollment with UnitedHealthcare. Projected enrollment assumes we will enroll 50 percent of the eligible population in the Anchorage Municipality and Mat-Su Borough regions, and 100 percent of the eligible population in the Fairbanks-North Star Borough and Juneau City and Borough. Membership includes 1 percent annual Medicaid program growth and an incremental 1.3 percent additional Alaska Native enrollment in the first two years of the program. Per the Data Book narrative, **services include** inpatient hospital, outpatient hospital, professional, pharmacy, LTSS, BH and ancillary services. **Populations include** Blind and Disabled, CHIP, Dual-Eligible, Managed Care Optional, Medicaid – Adult, Medicaid – Child, Medicaid – Expansion, Old Age

Assistance, Pregnant Women, Tax Equity and Fiscal Responsibility Act (TEFRA), and Waiver (c).

Program Change Adjustments: No information was provided regarding Alaska Medicaid benefit, population or fee schedule changes during the base data period or over the projection period, with the exception of the Medicaid Expansion rollout effective in September 2016. Therefore, we did not make any additional adjustments to account for retrospective or prospective programmatic changes. To the extent that these types of changes occurred and could have materially altered the data, our Pro Forma would be impacted accordingly.

Prospective Medical Trend is an estimate of the change in the overall costs of providing benefits over a specific period. Typical components of a trend factor include changes in service costs and utilization. A trend factor is necessary to estimate the expenses of providing health care services in some future year, based upon expenses incurred in prior years. Trend values typically realized in an FFS program will vary from those in a managed program. Trends applied to the proposed project were modeled after trends realized in a managed program. We applied trend factors to the base data to project from the mid-point of the base period to the mid-point of each year included in the project. The annual trend factors applied were derived from several sources: analysis of year-over-year changes between SFY2015 and SFY2016 in the Alaska Medicaid Data Book by population; review of utilization trends for existing UnitedHealthcare book in similar markets; external consulting firm review of similar markets; and other external published trend sources, including the CMS Office of the Actuary Medicare FFS trend projections and Kaiser Family Foundation State Health Facts. Overall annual managed care trends used in the Proposed Project are shown in the following table:

UnitedHealthcare Managed Care Trend				
Product	**Family**	**CHIP**	**Expansion**	**ABD/LTSS**
All Services	2%	4%	3%	2%

Managed Care Assumptions: The proposed project has the potential to generate savings over an unmanaged FFS population through several means including, but not limited to, a Whole Person Care model that fully integrates clinical and BH services, including coordination of LTSS; improving access to preventive services and primary care; promoting preventive services, primary care and healthy behaviors; case management; and incorporation of value-based payment mechanisms. We captured the savings generated from this change in the management of the delivery system in a managed care savings adjustment and applied to the base utilization data. These adjustments vary by category of service and population. For example, inappropriate use of inpatient hospitalization and ER services can be minimized by improving access to preventive services and primary care. However, the emphasis on those preventive services could drive increased utilization of physician services. Additionally, certain populations present more opportunities for improved utilization through care management and care coordination than others.

We developed managed care savings estimates through a thorough review of the Alaska Medicaid Data Book, our existing experience, and data from similar markets, and through an external consulting firm's review of similar markets. These savings from managed care activities take time before they are fully realized. Evaluating and assessing members' needs while improving access to, and encouraging utilization of, more appropriate care may limit savings potential in the initial months of a new program. Additionally, certain programmatic controls (such as limitations on preferred drug lists, continuity of care provisions, etc.) might limit the managed care plans' ability to delivery savings in those initial months. The managed care savings estimates used in our Pro Forma are ramped up over the initial year of the program.

The following table shows the managed care savings assumptions by population *after* the full 12-month ramp-up period.

Alaska Managed Care Savings				
Product	**Family**	**CHIP**	**Expansion**	**ABD/LTSS**
All Services	7%	8%	8%	7%

Administrative Expense: For the Pro Forma, we included an adjustment for non-medical load to cover managed care administrative costs, risk, profit and contingencies. We developed the administrative costs using a zero-based build approach to reflect the specific requirements of the RFP and based upon our current internal costs of providing required support services. Clinical employees and related expenses are included in our administrative cost build and are based upon our internal staffing models that are consistent with the requirements of the RFP. We based risk, profit and contingency adjustments upon our assessment of the inherent risks associated with bidding in a capitated Medicaid environment and allowing for an adequate return. Total non-medical load assumed in the Pro Forma was 8.0 percent.

C. Provide an annual budget neutrality projection for the proposed project that compares State expenditures under the current system, as provided in the Alaska Medicaid Data Book, to what would occur under the proposed project:

1) Using the 2015 total average PMPM baseline cost from the data book, project the total average PMPM cost and utilization by the Medicaid populations served in 2018.

The underlying medical utilization and PMPM projection for the initial three years of the proposed project is provided in Attachment 4.02.07.C.1. – Utilization and PMPM Projection. The attachment includes two sections with columns from left to right. The **Estimated Utilization** and **PMPM under the Current System** assume no changes to current system. The proposed Project Target Population identifies the expected enrollment and projected medical experience assuming no changes to the current system. The Population Remaining Fee-for-Service identifies the population expected to remain in FFS and their projected medical experience. The Total Statewide is the sum of the target population and the population that remains FFS. **The Estimated Utilization** and **PMPM under the Proposed Project** show the impact of managed care on the target population. Proposed Project Target Population identifies the expected enrollment and projected medical experience, assuming enrollment in managed care. Population Remaining Fee-for-Service identifies the population expected to remain in FFS and their projected medical experience. This population is not impacted by managed care. Total Statewide is the sum of the target population and the population that remains FFS.

2) Describe the major assumptions underlying the neutrality projections

Assumptions: We provide an annual budget neutrality projection for the initial three years of the proposed project in Attachment 4.02.07.C.2. – Budget Neutrality Projection. There are several key assumptions underlying the State Budget Projection and the Proposed Project Budget Projection, which are summarized herein and described in more detail in our response to RFP Section 4.02.07 B.

Medical Base Data: We relied exclusively on SFY2016 historical claims experience and Milliman's completion factor assumptions provided in the Alaska Medicaid Data Book for all populations, regions and services. We performed reasonability checks where possible, but the detailed, claim-level data from the State payment systems needed to perform an independent audit of this data was not provided. Errors in data reporting would therefore flow through to the projections.

Membership: Our neutrality projections assume Statewide membership growth of 2 percent annually. While the Proposed Project does not apply to all regions, it was necessary to include

all populations and services in the State Budget Projection to demonstrate statewide budget neutrality.

The Proposed Project Coverage Area: The Proposed Project covers all populations and services in the Anchorage Municipality, Matanuska-Susitna Borough, Fairbanks-North Star Borough, and Juneau City and Borough with adjustments for AI/AN enrollment, market share penetration and annual Medicaid program growth.

Program Change Adjustments: No information was provided regarding Alaska Medicaid benefit, population or fee schedule changes during the base data period or over the projection period, with the exception of the Medicaid Expansion rollout effective in September 2016. Therefore, we did not make any additional adjustments to account for retrospective or prospective programmatic changes. To the extent that these types of changes occurred and could have materially altered the data, our Budget Projections would be impacted accordingly.

Prospective Medical Trend: The annual trend factors applied to the State Budget Projection were modeled after trends realized in an FFS program. Trends applied to the Proposed Project Budget Projection were modeled after trends realized in a managed program. We applied trend factors to the base data to project from the mid-point of the base period to the mid-point of each year included in the project. The annual trend factors applied were derived from several sources: analysis of year-over-year changes between SFY2015 and SFY2016 in the Alaska Medicaid Data Book by population, review of utilization trends for existing UnitedHealthcare book in similar markets, external consulting firm review of similar markets, and other external published trend sources, such as the CMS Office of the Actuary Medicare FFS trend projections and Kaiser Family Foundation State Health Facts. Overall annual FFS trends used in the State Budget Projection are shown in the following table:

Alaska FFS Trend				
Product	**Family**	**CHIP**	**Expansion**	**ABD/LTSS**
All Services	4%	6%	6%	2%

Overall annual managed care trends used in the Proposed Project Budget Projection are shown in the following table:

UnitedHealthcare Managed Care Trend				
Product	**Family**	**CHIP**	**Expansion**	**ABD/LTSS**
All Services	2%	4%	3%	2%

Managed Care Assumptions: The proposed project has the potential to generate savings over an unmanaged FFS population through several means, which are captured in a managed care savings adjustment and applied to the base utilization data. We developed managed care savings estimates through a thorough review of the Alaska Medicaid Data Book, our existing experience and data from similar markets, and through an external consulting firm's review of similar markets. These savings from managed care activities take time before they are fully realized. The managed care savings estimates used in our Proposed Project Budget Projection are ramped up over the initial year of the program. The following table shows the managed care savings assumptions by population *after* the full 12-month ramp-up period.

Alaska Managed Care Savings				
Product	**Family**	**CHIP**	**Expansion**	**ABD/LTSS**
All Services	7%	8%	8%	7%

Administrative Expense: States incur administrative expenses over and above claims expenses as they bear the full responsibility of administration and costs for all of the services in the system. These state administrative expenses contribute to the total programmatic costs, and should be an important component in evaluating options to improve the state's Medicaid program. While there will typically be some level of expenses borne by the state to administer any program, the proposed project presents opportunities to streamline the system to yield significant savings by offsetting current state administrative expenses. Services that will be offset under the proposed project include member services, provider services, care coordination, medical management, quality improvement, claims payment, grievance and appeals, and compliance.

Consistent with publicly available information from the Kaiser Family Foundation and the Medicaid and CHIP Payment and Access Commission (MACPAC), we included an estimate for current State administrative expenses of 8.5 percent. This administrative expense is assumed to decrease to 6.5 percent for the impacted regions and populations covered under the proposed project. For the Proposed Project Budget Projection, we included an adjustment for non-medical load to cover managed care administrative costs, risk, profit and contingencies. Administrative costs were developed using a zero-based build approach to reflect the specific requirements of the RFP and are based upon our current internal costs of providing required support services. Clinical employees and related expenses are included in our administrative cost build and are based upon our internal staffing models that are consistent with the requirements of the RFP. Risk, profit and contingency adjustments were based upon our assessment of the inherent risks associated with bidding in a capitated Medicaid environment and allowing for an adequate return. Total non-medical load assumed in the Proposed Project Budget Projection was 8.0 percent.

3) The forecast should demonstrate budget neutrality in year one and net savings to the State in years two and three. Describe any major assumptions underlying the neutrality projections.

An annual **budget neutrality** projection for the initial three years of the proposed project is provided in the Attachment 4.02.07.C.2. – Budget Neutrality Projection. The attachment includes three sections in columns from left to right: **Proposed Project Target Population** identifies the expected enrollment and projected medical experience assuming enrollment in managed care; **Population Remaining Fee-for-Service** identifies the population expected to remain in FFS and their projected medical experience (this population is not impacted by managed care); and **Total Statewide**, the sum of the target population and the population that remains FFS. A summary of the estimated potential savings is shown in the following table:

Total Statewide			
Savings to State Budget	**2018**	**2019**	**2020**
Medical Savings	$ –	$ 4,778,481	$ 12,698,462
% of Total State Expenditures	0.0%	0.2%	0.5%
Administrative Savings	$ 9,590,442	$ 10,130,887	$ 10,647,962
% of Total State Expenditures	0.4%	0.4%	0.4%

As shown, the proposed project generates potential state savings through both state administrative and medical expense reductions. In total, the proposed project is estimated to yield $17.5M in medical savings and $30.4M in administrative savings over the initial three years of the project.

4.03.07 Financial Projections and Potential for Cost Containment or Savings (10 page maximum for additional information)

D. Provide an annual budget neutrality projection for the proposed project that compares State expenditures under the current system, as provided in the Alaska Medicaid Data Book, to what would occur under the proposed project:

1) Using the 2015 total average PMPM baseline cost from the data book, project the total average PMPM cost and utilization by the Medicaid populations served during the first three years of project operations.

The underlying medical utilization and PMPM projection for the initial three years of the proposed project is provided in Attachment 4.02.07.C.1. – Utilization and PMPM Projection. The attachment includes two sections with columns from left to right:

- Estimated Utilization and PMPM under the Current System – This section assumes no changes to current system.
  - ***Proposed Project Target Population:*** Identifies the expected enrollment and projected medical experience assuming no changes to the current system.
  - ***Population Remaining Fee-for-Service:*** Identifies the population expected to remain in FFS and their projected medical experience.
  - ***Total Statewide:*** This is the sum of the target population and the population that remains FFS.
- Estimated Utilization and PMPM under the Proposed Project – This section shows the impact of managed care on the target population.
  - ***Proposed Project Target Population:*** Identifies the expected enrollment and projected medical experience, assuming enrollment in managed care.
  - ***Population Remaining Fee-for-Service:*** Identifies the population expected to remain in FFS and their projected medical experience. This population is not impacted by managed care.
  - ***Total Statewide:*** This is the sum of the target population and the population that remains FFS.

2) Calculate an estimated savings percentage that result from managed care initiatives on a year-by-year basis. Include and identify line items for year one start-up costs, year one claims run-out set to equal 15 percent of expenditures, and anticipated administrative costs.

Attachment 04.02.07.C.2 – Budget Neutrality Projection details the program savings calculation for the Proposed Project on a year-by-year basis, including the amount and percentage of savings resulting from managed care initiatives. These savings from managed care activities take time before they are fully realized. Evaluating and assessing members' needs while improving access to, and encouraging utilization of, more appropriate care may limit savings potential in the initial months of a new program. Additionally, certain programmatic controls (such as limitations on preferred drug lists, continuity of care provisions, etc.) might limit the managed care plans' ability to deliver savings in those initial months. The managed care savings estimates used in our Proposed Project Budget Projection are ramped up over the initial year of the program. The following table shows the managed care savings assumptions by population *after* the full 12-month ramp-up period.

Alaska Managed Care Savings				
Product	**Family**	**CHIP**	**Expansion**	**ABD/LTSS**
All Services	7%	8%	8%	7%

Attachment 04.02.07.C.2 – Budget Neutrality Projection includes a line item for the claims run-out on FFS claims incurred prior to Jan. 1, 2018, which the State would fund, that are anticipated to be paid after Jan. 1, 2018. As noted previously, this was required to be set at 15 percent of expenditures. Anticipated administrative costs are also shown in the Attachment 04.02.07.C.2 – Budget Neutrality Projection.

The monthly Pro Forma financial projection for the Proposed Project in Attachment 4.02.07.B – Pro Forma includes a single line item for the total year one start-up costs. This was not included in the Budget Neutrality Projection as it was indicated that these costs would not be funded by the Department and are the responsibility of the offeror. More information on these costs is included in the response to Section ***4.02.05 4B***. The line item details are shown in the table.

AK MEDICAID START-UP COST RAMP												
	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Total
Workforce Costs	$ -	$ 0.0	$ 0.1	$ 0.1	$ 0.2	$ 0.4	$ 0.4	$ 0.4	$ 0.6	$ 1.1	$ 1.3	$ 1.4	$ 6.0
Non-Workforce Costs	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.0	$ 0.1	$ 0.1	$ 0.1	$ 0.1	$ 0.4	$ 0.3	$ 0.4	$ 1.6
IT Capital	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.5	$ 0.5	$ 0.5	$ 0.5	$ 2.1
Total Start-up ($M)	$ 0.0	$ 0.1	$ 0.1	$ 0.2	$ 0.2	$ 0.4	$ 0.5	$ 0.6	$ 1.3	$ 1.9	$ 2.1	$ 2.4	$ 9.7

3) Show how estimated savings were calculated

Attachment 04.02.07.C.2 – Budget Neutrality Projection details the program savings calculation for the Proposed Project on a year-by-year basis. Program savings can be achieved through savings from managed care activities and reduction in state administrative expenses.

Savings from Managed Care Activities

The proposed project has the potential to generate savings over an unmanaged FFS population through several means including, but not limited to:

- A Whole Person Care model that fully integrates clinical and BH services, including coordination of LTSS
- Improving access to preventive services and primary care
- Promoting preventive services, primary care and healthy behaviors
- Case management
- Incorporation of value-based payment mechanisms

The savings generated from this change in the management of the delivery system are captured in a managed care savings adjustment and applied to the base utilization data. These adjustments vary by category of service and population. For example, inappropriate use of inpatient hospitalization and ER services can be minimized by improving access to preventive services and primary care. However, the emphasis on those preventive services could drive increased utilization of physician services. Additionally, certain populations present more opportunities for improved utilization through care management and care coordination than others. We developed managed care savings estimates through a thorough review of existing UnitedHealthcare experience in the Alaska Medicaid Data Book, other data from similar markets, and through an external consulting firm's review of similar markets.

These savings from managed care activities take time before they are fully realized. Evaluating and assessing members' needs while improving access to, and encouraging utilization of, more appropriate care may limit savings potential in the initial months of a new program. Additionally, certain programmatic controls (such as limitations on preferred drug lists, continuity of care

provisions, etc.) might limit the managed care plans' ability to deliver savings in those initial months. The managed care savings estimates used in our Proposed Project Budget Projection are ramped up over the initial year of the program. The following table shows the managed care savings assumptions by population *after* the full 12-month ramp-up period.

Alaska Managed Care Savings				
Product	**Family**	**CHIP**	**Expansion**	**ABD/LTSS**
All Services	7%	8%	8%	7%

After determining the managed care savings adjustment, these factors were applied to the baseline trended Alaska Medicaid Data Book experience by category of service to calculate a medical savings estimate.

Reduction in State Administrative Expense

States incur administrative expenses over and above claims expenses as they bear the full responsibility of administration and costs for all of the services in the system. These State administrative expenses contribute to the total programmatic costs, and should be an important component in evaluating options to improve the State's Medicaid program. While there will typically be some level of expenses borne by the State to administer any program, the proposed project presents opportunities to streamline the system to yield significant savings by offsetting current State administrative expenses. Services that will be offset under the proposed project include, member services, provider services, care coordination, medical management, quality improvement, claims payment, grievance and appeals, and compliance. Consistent with publicly available information available from the Kaiser Family Foundation and MACPAC, we included an estimate for current State administrative expenses of 8.5 percent. This administrative expense is assumed to decrease to 6.5 percent for the impacted regions and populations covered under the proposed project.

4) Describe the underlying assumptions.

Assumptions

An annual budget neutrality projection for the initial three years of the proposed project is provided in the Attachment 04.02.07.C.2 – Budget Neutrality Projection. There are several key assumptions underlying the State Budget Projection and the Proposed Project Budget Projection, which are described herein.

Medical Base Data

For both projections, we relied exclusively on historical claims experience provided in the Alaska Medicaid Data Book when establishing the basis for the projection. Specifically, SFY2016 was established as the base data period (dates of service from July 1, 2015, through June 30, 2016) for all populations, regions and services. It was necessary to use SFY2016 in the projection due to the Medicaid Expansion population that was rolled out in SFY2016. Furthermore, some populations saw significant enrollment changes between SFY2015 and SFY2016. For example, CHIP had a 20 percent increase in membership and Pregnant Women grew 18 percent, but the Waiver (c) Composite population decreased 6 percent over that time. It was therefore necessary to use SFY2016 to reflect the most current population and expenditure information. Additionally, we used the estimated completion factor assumptions provided by Milliman in the Alaska Medicaid Data Book to adjust the base data for incurred but not paid (IBNP) claims. The following table shows the completion factors used in the projection.

Alaska Managed Care Savings		
COS	**SFY2015**	**SFY2016**
Inpatient Hospital	1.009	1.133
Outpatient Hospital	1.006	1.070
Professional	1.002	1.081
ER	1.006	1.070
Pharmacy	1.000	1.005
Ancillaries	1.003	1.028
LTSS	1.003	1.027
BH	1.006	1.063
Total	**1.004**	**1.060**

No additional base data adjustments were made for this projection. Prospective adjustments are described in the following sections. We relied exclusively on the Alaska Medicaid Data Book that was provided to develop the State Budget Projection. Reasonability checks were performed where possible, but the detailed, claim-level data from the State payment systems needed to perform an independent audit of this data was not provided. Errors in data reporting would therefore flow through to the projections.

Covered Populations

Our State Budget Projection applies to all covered populations and services summarized in the Alaska Medicaid Data Book. Membership was projected to grow by 2 percent annually. While the Proposed Project does not apply to all regions, it was necessary to include all populations and services in the State Budget Projection to demonstrate statewide budget neutrality. Per the data book narrative:

- ***Services include:*** Inpatient hospital, outpatient hospital, professional, pharmacy, LTSS, BH and ancillary services.
- ***Populations include:*** Blind and Disabled, CHIP, Dual-Eligible, Managed Care Optional, Medicaid – Adult, Medicaid – Child, Medicaid – Expansion, Old Age Assistance, Pregnant Women, Tax Equity and Fiscal Responsibility Act (TEFRA), and Waiver (c).

The Proposed Project Budget Projection applies only to the following regions: Anchorage Municipality, Mat-Su Borough, Fairbanks-North Star Borough, and Juneau City and Borough. The Proposed Project covers all populations and services in those regions; however, adjustments were made to the assumed membership that would be enrolled in the Project:

- As the AI/AN populations are exempt from mandatory enrollment in a managed care plan, projected enrollment assumes only 3.3 percent of the AI/AN eligible population in the Proposed Project regions will select enrollment with UnitedHealthcare.
- Projected enrollment assumes we will enroll 50 percent of the eligible population in the Anchorage Municipality and Mat-Su Borough regions, and 100 percent of the eligible population in the Fairbanks-North Star Borough and Juneau City and Borough, excluding the AI/AN population noted previously.
- Membership includes 1 percent annual Medicaid program growth and an incremental 1.3 percent additional Alaska Native enrollment in the first two years of the program.

Program Change Adjustments: No information was provided regarding Alaska Medicaid benefit, population or fee schedule changes during the base data period or over the projection period, with the exception of the Medicaid Expansion rollout effective in September 2016.

Therefore, we did not make any additional adjustments to account for retrospective or prospective programmatic changes. To the extent that these types of changes occurred and could have materially altered the data, our Budget Projections would be impacted accordingly.

Prospective Medical Trend: Trend is an estimate of the change in the overall costs of providing benefits over a specific period. Typical components of a trend factor include changes in service costs and utilization. A trend factor is necessary to estimate the expenses of providing health care services in some future year, based upon expenses incurred in prior years. Trend values typically realized in an FFS program will vary from those in a managed program. We modeled the annual trend factors applied to the State Budget Projection after trends realized in an FFS program. Trends applied to the Proposed Project Budget Projection were modeled after trends realized in a managed program. We applied trend factors to the base data to project from the mid-point of the base period to the mid-point of each year included in the project. We derived the annual trend factors applied from several sources:

- Analysis of year-over-year changes between SFY2015 and SFY2016 in the Alaska Medicaid Data Book by population
- Review of utilization trends for existing UnitedHealthcare book in similar markets
- External consulting firm review of similar markets
- Other external published trend sources, including sources such as the CMS Office of the Actuary Medicare FFS trend projections and Kaiser Family Foundation State Health Facts

Overall annual FFS trends used in the State Budget Projection are shown in the following table:

Alaska FFS Trend				
Product	**Family**	**CHIP**	**Expansion**	**ABD/LTSS**
All Services	4%	6%	6%	2%

Overall annual managed care trends used in the Proposed Project Budget Projection are shown in the table:

UnitedHealthcare Managed Care Trend				
Product	**Family**	**CHIP**	**Expansion**	**ABD/LTSS**
All Services	2%	4%	3%	2%

Managed Care Assumptions: Medicaid MCOs have the potential to generate savings over an unmanaged FFS population through several means including, but not limited to:

- Improving access to preventive services and primary care
- Promoting preventive services, primary care and healthy behaviors
- Case management

The savings generated from this change in the management of the delivery system are captured in a managed care savings adjustment and applied to the base utilization data. These adjustments vary by category of service and population. For example, inappropriate use of inpatient hospitalization and ER services can be minimized by improving access to preventive services and primary care. However, the emphasis on those preventive services could drive increased utilization of physician services. Additionally, certain populations present more opportunities for improved utilization through care management and care coordination than others. We developed managed care savings estimates through a thorough review of the

Alaska Medicaid Data Book, existing UnitedHealthcare experience and data from similar markets, and through an external consulting firm's review of similar markets.

These savings from managed care activities take time before they are fully realized. Evaluating and assessing members' needs while improving access to, and encouraging utilization of, more appropriate care may limit savings potential in the initial months of a new program. Additionally, certain programmatic controls (such as limitations on preferred drug lists, continuity of care provisions, etc.) might limit the managed care plans' ability to deliver savings in those initial months. The managed care savings estimates used in our Proposed Project Budget Projection are ramped up over the initial year of the program. The following table shows the managed care savings assumptions by population *after* the full 12-month ramp-up period.

Alaska Managed Care Savings				
Product	**Family**	**CHIP**	**Expansion**	**ABD/LTSS**
All Services	7%	8%	8%	7%

Administrative Expense: States incur administrative expenses over and above claims expenses as they bear the full responsibility of administration and costs for all of the services in the system. These State administrative expenses contribute to the total programmatic costs, and should be an important component in evaluating options to improve the State's Medicaid program. While there will typically be some level of expenses borne by the State to administer any program, the proposed project presents opportunities to streamline the system to yield significant savings by offsetting current State administrative expenses. Services that will be offset under the proposed project include, member services, provider services, care coordination, medical management, quality improvement, claims payment, grievance and appeals, and compliance.

Consistent with publicly available information from the Kaiser Family Foundation and MACPAC, we included an estimate for current State administrative expenses of 8.5 percent. This administrative expense is assumed to decrease to 6.5 percent for the impacted regions and populations covered under the proposed project.

For the Proposed Project Budget Projection, we included an adjustment for non-medical load to cover managed care administrative costs, risk, profit and contingencies. Administrative costs were developed using a zero-based build approach to reflect the specific requirements of the RFP and are based upon our current internal costs of providing required support services. Clinical employees and related expenses are included in our administrative cost build and are based upon our internal staffing models that are consistent with the requirements of the RFP. Risk, profit and contingency adjustments were based upon our assessment of the inherent risks associated with bidding in a capitated Medicaid environment and allowing for an adequate return. Total non-medical load assumed in the Proposed Project Budget Projection was 8.0 percent.

5) The forecast should demonstrate budget neutrality in year one and net savings to the State in years two and three.

An annual budget neutrality projection for the initial three years of the proposed project is provided in Attachment 04.02.07.C.2 – Budget Neutrality Projection. The attachment includes three sections in columns from left to right:

- ***Proposed Project Target Population:*** Identifies the expected enrollment and projected medical experience assuming enrollment in managed care.

- ***Population Remaining Fee-for-Service:*** Identifies the population expected to remain in FFS and their projected medical experience. This population is not impacted by managed care.
- ***Total Statewide:*** This is the sum of the target population and the population that remains FFS.

A summary of the estimated potential savings is shown in the following table:

Total Statewide			
Savings to State Budget	**2018**	**2019**	**2020**
Medical Savings	$ –	$ 4,778,481	$ 12,698,462
% of Total State Expenditures	0.0%	0.2%	0.5%
Administrative Savings	$ 9,590,442	$ 10,130,887	$ 10,647,962
% of Total State Expenditures	0.4%	0.4%	0.4%

As shown, the proposed project generates potential state savings through both state administrative and medical expense reductions. In total, the proposed project is estimated to yield $17.5M in medical savings and $30.4M in administrative savings over the initial three years of the project.

4.02.08 Potential for Improving Care and Outcomes for Medicaid Enrollees (5 page maximum)

A. Identify a minimum of five (5) and maximum of 20 quality and outcome measures that would be targeted for improvement under the proposed model and provide a percentage improvement goal for the first 36 months of operations. The offeror may refer to Healthy Alaskans 2020 as a source of key indicators and health improvement goals the Department supports at a statewide population level (see Section 2.04 for a link to the Healthy Alaskans 2020 website).

We use proven processes to select, monitor, evaluate and improve the quality of health care for members receiving integrated medical and BH care. These processes include:

- ***Selection*** of quality and outcome measures that reflect member health and well-being through our clinical quality research teams. These clinical quality research teams review current literature, bring together subject matter experts via advisory councils, survey changes in the Medicaid environment and keep abreast of Agency for Healthcare Research and Quality (AHRQ) and National Quality Foundation (NQF) best practice initiatives. Their work also includes querying NCQA benchmarks and analysis of regional and health plan variation across our businesses and examining member demographic data, condition prevalence and incidence rates.
- ***Monitoring*** of quality and outcome measures using standardized measure criteria, data accuracy reviews and reporting.
- ***Evaluating and improving*** upon selected measures through regular presentations to the standing Quality Management Committee (QMC). This process ensures oversight by expert clinical staff on a committee chaired by the chief medical officer, and includes implementation of rapid-cycle changes to interventions using Plan-Do-Study-Act (PDSA) processes. The QMC confirms planning and allocation of appropriate resources to continue or modify improvement efforts for each selected metric, and is able to reference best practices across 25 Medicaid plans. Supported by the member engagement team, the team applies various quasi-experimental design statistical analyses to assess efficacy of interventions when use of case/control groups are not possible. This group includes a team of certified lean six-sigma black belts who convene groups to develop new interventions or recommend elimination of ineffective programs.

Improvement Through Physician and Member Engagement

Our experience in the 25 state Medicaid markets we serve allows us to build, implement and test effective quality improvement programs. We find the most effective interventions connect the member to the health care system and developing a physician network that has the support required to actively seek out and track members to meet a wide array of needs. We complement physician efforts with specific member outreach programs through a variety of modalities. Selection of quality measures to improve member health reflects this improvement strategy through assessment of member preventive health encounters with health care providers. **We have selected 14 outcome measures to target Healthy Alaskans 2020 priorities through physician screening and discussions with members, followed by appropriate education, referral to support services and follow-up care.**

The following table illustrates the outcome measures that reflect appropriate member engagement with health care that lead to improvements for the majority of Healthy Alaskans priorities and other important quality and outcome measures. Review of past multiyear performance improvement projects, year-over-year improvements, NCQA benchmarks and published rates for some Alaskan health plans were used to estimate likely baseline performance levels, and likely performance improvements over a three-year period.

#	Outcome Measures: Quality Improvement Framework – Healthy Alaskans 2020	% Goal*
1	***Cervical Cancer Screening:*** Correlation with annual well exam and prior success of direct member outreach programs	3%
2	***Diabetic HbA1c Screen:*** Positive results by moving members to routine PCP visits; clinical practice consultant (CPC) supply of known HbA1c gaps to PCPs; and moderate success of direct member outreach	8%
3	***Diabetic Eye Exam:*** Direct member outreach shown effective in past interventions.	5%
4	***Diabetic HbA1c<9:*** Medication and lifestyle changes required. We will implement engagement in disease management and CPC coordination with PCPs to achieve goals.	1.5%
5	***Follow Up After Hospitalization for Mental Illness Within Seven Days of Discharge:*** Reduction of suicidal rates.	1%
6	***Childhood Immunizations Status:*** Combo 3: Parents/guardians typically complete immunizations spanning the first six months of life; campaigns to create monthly "touch points" in a child's life have proven effective; additional possibilities via CPCs and physician group incentives.	6%
7	***Immunizations for Adolescents:*** Correlated with annual well visits. Direct member reward campaigns for annual visits and CPC actions are effective.	4%
8	***Chlamydia Screening in Women:*** Correlated with annual well visits, CPCs are able to supply lists to cooperating PCPs.	7%
9	***Well-Child Visits – First 15 months of Life:*** Fewer than 15 percent of parents/guardians typically fail to complete first three visits. Monthly touch points with members support completion of all six visits. Targeted calls from our member advocate team produce reliable improvements.	6%
10	***Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life:*** Direct member advocate calls produce 6-8 percent improvement. Member rewards programs and well visits are important to anticipatory guidance and referrals regarding weight, tobacco use and any developmental delays.	7%
11	***Adolescent Well-Care Visits:*** Direct calls from our member advocate team produce 6-8 percent improvement. Member reward programs also effective. More difficult to address than 3- to 6-year-olds. Well visits are important to anticipatory guidance and referrals regarding weight, tobacco use and high-risk behaviors.	5%
12	***Children and Adolescents' Access to PCPs:*** Child/adolescent engagement with health care system critical for addressing health care needs and avoiding inappropriate utilization of health care. We anticipate baseline rates to be high.	3%
13	***Adults' Access to Preventive/Ambulatory Health Services:*** CPCs, Value-Based Contracts and direct member outreach address this metric. Regular adult preventive visits and PCP drive discussions and follow-up actions for adult tobacco use, high body mass index and important referrals.	6%
14	***Timeliness of Prenatal Care:*** Timely identification, member phone engagement by our member advocate team and health screening is critical to improved health outcomes. Engagement of women in routine health care (before pregnancy) promotes timely PCP contact. Weekly review of administrative data and access to state data file transfers for pregnant members enrolling in Medicaid will increase the success of phone contact campaigns and member enrollment in our *Baby Blocks* program.	7%
**** % Goal = Improvement Goal (36-month period)***		

OTHER QUALITY MEASUREMENT AND INTERVENTIONS

In addition to standardized CMS Core and HEDIS metrics based upon claims and chart audits, our quality improvement strategy includes monitoring and intervening upon a variety of other indicators that address key aspects of member care and experience.

- ***EPSDT:*** Our EPSDT program is comprehensive and focuses on the continuum of care through health need assessment, preventive screening, initiating referrals, completing recommended medical treatment and appropriate follow up for physical and BH services as allowable under federal law. We have extensive experience deploying programs to address monitoring of CMS EPSDT requirements, improving EPSDT participation rates, ensuring providers conduct appropriate developmental screenings and acting upon referrals arising from annual well visits. The screenings and applicable education and age-appropriate anticipatory guidance required under this program are critical to addressing such areas as childhood obesity, smoking and sexually transmitted disease prevention during conversations between physicians and parents/guardians.
- ***CAHPS:*** We use CAHPS surveys to obtain information about the quality of health plan care from the member's perspective. This is a key source of data on member satisfaction and provides important information, such as access to his/her care and physician communication. In addition to general domains, the adult survey assesses areas such as smoking/tobacco use, and member efforts to quit. CAHPS survey results allow us to work with our physician network to drive quality improvements in areas specific to our population.
- ***LTSS:*** To date, there has been little consensus from the federal government and state Medicaid agencies around which quality measures are most appropriate for monitoring the care delivered to complex subpopulations such as those with a disability who use LTSS. Work related to measuring the quality of LTSS services is limited when compared to other Medicaid populations. This is partially due to the unique functional and health care needs of this population, which require highly individualized treatment and interactions. As part of the work of our clinical quality research team activities, we convened a National Advisory Board in 2015 to develop a quality improvement framework to address LTSS populations. This framework includes extensive assessment via administrative data and HCBS member surveys to assess quality of LTSS services and care coordination, access to care, ability to live independently, ability to engage in independent decision-making and community integration. Member experience and amelioration of depression, and a strong focus on common chronic conditions such as diabetes are also part of the framework. We have provided an example of the impact of these processes in the accompanying table.

State Examples of HEDIS Outcomes		
Arizona Long-Term Care Measures	**2015**	**2016**
CDC – Eye Exam	33.43%	50.73%
CDC – HbA1c Testing	36.67%	48.80%

B. Provide baseline data and improvement goals for each of the first 36 months of operation for inpatient hospital admissions and days, emergency room visits, and primary care visits per 1,000 member enrollees.

We understand the importance of reducing inpatient hospital admissions and readmissions. Based upon our analysis of hospital utilization rates provided in the data book, comparison to those states with established managed care programs and knowledge of Alaska's utilization patterns, we believe there is considerable potential to reduce hospital utilization, reduce ER visits and increase PCP visits. Extrapolating from the Data Book, we expect Alaska FFS to have inpatient days/1,000 of 803.6 and ER/1,000 of 835.1 as the baseline at 36 months. **We expect a 29.1 percent reduction in that baseline inpatient in the first 36 months and a 23.4 percent reduction in ER in the first 36 months.** While we determined this to be aggressive in the first year, our experience in other newly managed care markets has shown this is reasonably attainable in aggregate over the course of the first 36 months. By implementing the strategies discussed in the following sections, we believe we can achieve similar hospital utilization and ER reductions and increases in PCP visits in the CCDP.

C. Describe how the proposed project will support attainment of these improvement goals, and describe the basis for the expectation that the proposed project will result in attainment of the goals (e.g., literature review).

We will implement a variety of intervention programs throughout the first 36 months of operation. Every program we implement was developed, deployed and evaluated in other Medicaid health plans. To estimate likely baseline rates, we used research from our member engagement team, available NCQA benchmarks, UnitedHealthcare Medicaid plan performance along with limited Alaska commercial information relative to performance for our commercial plans in other markets. To estimate expected improvements, we used proprietary data from improvements deployed in other Medicaid markets. We propose these same interventions in Alaska. Our estimates are the result of our certified lean six-sigma black belt analysis teams that evaluate interventions and verify that only effective programs are redeployed in subsequent years. The accompanying table shows the percent HEDIS improvements observed following past interventions for our New Jersey health plan. We will use the following key interventions in Alaska:

UnitedHealthcare New Jersey Medicaid	HEDIS %		
	2014	2015	2016
Comprehensive Diabetes Care – HbA1c Testing	83.87	84.72	85.12
Comprehensive Diabetes Care – HbA1c Control (<8 percent)	40.27	46.94	45.62
Comprehensive Diabetes Care – Eye Exams	53.07	54.03	57.86
Comprehensive Diabetes Care – Medical Attention for Nephropathy	78.40	79.17	90.68
Follow Up After Hospitalization for Mental Illness – Seven Days	15.97	51.38	57.04
Chlamydia Screening in Women – Total	53.71	55.66	58.57
Well-Child Visits in the first 15 Months of Life (6 or more visits)	65.82	68.62	64.96
Children and Adolescents' Access to PCPs	92.88	93.03	94.69
Prenatal and Postpartum Care – Timeliness of Prenatal Care	61.18	84.18	81.27

- ***Interactive Voice Recognition (IVR) Calls:*** The impact of IVR calling upon different measures is variable and past interventions have shown changes from 2 to 9 percent depending upon the state and the type of measure addressed. In conjunction with a postcard, IVR calls have produced improvements in well-woman exams greater than 4 percent.
- ***Member Advocate Calls:*** Member advocate calls can produce improvements of 5 percent. Typically, when a member can arrange transportation or the calls support other program initiatives, enhanced improvement occurs.
- ***Member Incentives:*** Member incentives to a PCP (or other provider) visits consistently produce **improvements of approximately 5 percent for closed gaps in care**.
- ***Clinical Practice Consultants (CPCs):*** Our CPCs meet regularly with providers, create trusted relationships, educate and communicate member gaps in care, and serve as experts in local community health care issues and barriers. This includes helping practices use information supplied through our portals and CPC visits regarding gaps in care and provider "score card" on current performance to redesign visits and services to support better outcomes, and helping to change office process flows to promote follow up on tests and needed visits. When deployed in Medicaid markets, **measures can improve from 3 percent to more than 15 percent**, depending upon number and size of physician groups and measures targeted.
- ***Provider Incentives:*** We use provider incentives to promote achievement of designated quality measures. These include value-based contracts for large physician groups, which have shown improvements for targeted measures.

Quality Improvement Tools

We are able to monitor and supply effective interventions based upon an interrelated group of quality monitoring tools. We receive monthly HEDIS interim performance reports that guide our work throughout the year to verify outreach, care gap closing, provider education and member engagement actions achieve performance goals. These tools include:

- ***Data Monitoring:*** Using an NCQA-approved HEDIS database, we generate monthly prospective reports that include trending of expected versus actual results for any given month. These reports allow quality improvement staff and the QMC to identify areas where we are trending below goal. We can then determine if we need to initiate rapid intervention within a PDSA process cycle.
- ***Member-Level Reporting:*** We use the same systems to provide monthly member-level reporting to identify member gaps in care. We use this information for direct outreach activities — such as calls from our member advocate team — to set up a needed appointment or support member incentive programs.
- ***Provider-Level Reporting:*** We supply monthly reports to providers via in-person visits from CPCs. This information is also available through our online provider portal. This data gives providers a snapshot of their aggregate rates (i.e., a scorecard) to help guide them in achieving minimum standards, exceeding peers or meeting provider incentive agreements. The reports also include gaps in care data for members assigned to the practice, and relevant utilization patterns for each member.

Core Care Management to Improve Care and Outcomes

For members with complex care needs, we use targeted care management interventions to help manage the health concerns that may lead to inpatient utilization. Critical elements of our evidence-based approach include:

- ***Field-Based Integrated Care Teams:*** Our field-based, integrated care teams, comprising a community health worker (CHW), care manager and a licensed BH advocate, collaborate to manage the care of members. The care team's local presence and experience is critical to develop a level of trust with members so the team can help manage their needs and help them achieve their goals and desired outcomes.
- ***Algorithm-Based Blended Identification and Stratification Process:*** Our algorithm-based blended identification and stratification process generates a risk score and stratifies each member according to predicted future cost and utilization by analyzing demographic variables, future inpatient risk, prior year total cost of care spending, acute inpatient admissions, ER visits, pharmacy, BH, social determinants of health and chronic conditions. Using this analysis, we identify members who are at-risk for future inpatient utilization and outreach to members to engage them in care management.
- ***Proactive Health Monitoring:*** Our near-real-time approach to proactively monitor the member's health status helps to detect acute events that may lead to an escalation of his/her utilization. CommunityCare presents member information in a way that is actionable, such as alerting the care manager to members that are not managing their conditions (e.g., a member with diabetes who has an elevated HbA1c); members who have experienced an acute event, such as an inpatient admission; and members with gaps in care. When alerted to a change in health status, the care team will engage members with timely, targeted interventions to prevent an escalation of their conditions.