Technical Proposal

RFP Number: EVT0009267

Legal Name of Bidder: UnitedHealthcare of the Midwest, Inc.

Bidder's Mailing Address:

6860 W. 115th Street

Mail Route: KS015-M400

Overland Park, KS 66211

Designated Contact Person:

Name: Tawnie Schubert

Title: Proposal Director

Phone Number: 412-848-5618

Proposal Submission Deadline: January 4, 2024 by 2 p.m. CT

Table of Contents (Tab 1)

Creating Healthier Communities Alongside Our Neighbors

Our Members are our neighbors. We are part of the communities that we serve, and our experiences living and working in Kansas inform the way we care for our Members. We are committed to showing up, to serving our communities, and to supporting the health and well-being of all Kansans.

Kansans United

United Healthcare Community Plan

Table of Contents (Tab 1)

Technical Proposal

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Transmittal Letter (Tab 2)

Bringing Mental Health Resources to Communities Across the State

Our outreach team personally conducts Mental Health First Aid trainings in English and Spanish to equip people with evidence-based education and resources. The trainings empower community members to address mental health and substance use challenges in their families, schools and neighborhoods.

Kansans United

United Healthcare Community Plan

Transmittal Letter (Tab 2)

1. Tab 2 shall be labeled "Transmittal Letter" and contain the bidder's transmittal letter. The transmittal letter must attest to or respond to the following:

a. The bidder is the prime CONTRACTOR and identify all Subcontractors.

UnitedHealthcare of the Midwest, Inc. (UnitedHealthcare) is the legal entity that will function as the prime contractor for the scope of services associated with this RFP. Our subcontractors for this project include our internal affiliates: Dental Benefit Providers, Inc., March® Vision Care Group, Inc., OptumInsight, Inc., OptumRx, Inc., OptumHealth Care Solutions, LLC, United HealthCare Services, Inc., Optum Behavioral Health, Inc. and the following nonaffiliated subcontractors: ModivCare Solutions, LLC, and Pediatric Care Network (PCN).

b. The bidder is a corporation or other legal entity.

UnitedHealthcare of the Midwest, Inc. is a corporation.

c. No attempt has been made or will be made to induce any other person or firm to submit or not to submit a proposal.

No attempt has been made or will be made by UnitedHealthcare to induce any other person or firm to submit or not to submit a proposal in response to this RFP.

d. The bidder does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin or disability.

UnitedHealthcare does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin or disability.

e. No cost or pricing information has been included in the transmittal letter or the technical proposal.

UnitedHealthcare has not included cost or pricing information in the transmittal letter or technical proposal.

f. The bidder accepts all provisions found in Contractual Provisions Attachment DA-146a (see Attachment 7, Contractual Provisions Attachment DA-146a), which are incorporated by reference and made a part of this CONTRACT.

UnitedHealthcare accepts all provisions found in Contractual Provisions Attachment DA-146a (see Attachment 7, Contractual Provisions Attachment DA-146a), which are incorporated by reference and made a part of this contract.

g. The bidder accepts all requirements, terms, and conditions of the RFP. If the bidder has an objection to, or is unwilling to comply with, any of the requirements, terms, or conditions of the RFP, the bidder must identify the exceptions in writing, include the exceptions document in a separate tab labeled "Tab 2a", and include Tab 2a in the Table of Contents.

UnitedHealthcare accepts all requirements, terms and conditions of the RFP.

h. The bidder has no actual, apparent, or potential conflict of interest, direct or indirect, that would conflict with the performance of services under this contract. If the bidder has an

actual, apparent, or potential conflict of interest, the bidder must disclose the conflict of interest, include a proposed conflict of interest mitigation plan document in a separate tab labeled "Tab 2b", and include Tab 2b in the Table of Contents.

UnitedHealthcare has no actual, apparent or potential conflict of interest, direct or indirect, that would conflict with the performance of services under this contract.

i. The person signing the proposal is authorized to make decisions as to pricing quoted and has not participated, and will not participate, in any action contrary to the above statements.

Kevin Sparks is chief executive officer of UnitedHealthcare of the Midwest, Inc. and the person signing the proposal. Kevin Sparks is authorized to make representations on behalf of the organization. Kevin Sparks is also authorized to make decisions as to pricing quoted and has not participated, and will not participate, in any action contrary to the statements above.

j. Whether there is a reasonable probability that the bidder is or will be associated with any parent, affiliate, or subsidiary organization, either formally or informally, in supplying any service or furnishing any supplies or equipment to the bidder, which would relate to the performance of this contract. If the statement is in the affirmative, the bidder is required to submit with the proposal, written certification and authorization from the parent, affiliate, or subsidiary organization granting the State and/or the federal government the right to examine any directly pertinent books, documents, papers, and records involving such transactions related to the contract. Further, if at any time after a proposal is submitted, such an association arises, the bidder will obtain a similar certification and authorization and failure to do so will constitute grounds for termination for cause of the contract at the option of the State.

Several of our subcontractors are affiliates as identified in our response. Therefore, UnitedHealthcare or one of our subcontractors is or will be associated with any parent, affiliate or subsidiary organization, either formally or informally, in supplying any service or furnishing any supplies or equipment to the bidder, which would relate to the performance of this contract. A certification from UnitedHealthcare of the Midwest, Inc., authorizing Kansas and/or the federal government the right to examine any directly pertinent books, documents, papers and records involving such transactions related to the contract follows this transmittal letter.

k. The bidder agrees that any lost or reduced federal matching money resulting from unacceptable performance in a CONTRACTOR task or responsibility defined in the RFP, CONTRACT, or modification shall be accompanied by reductions in state payments to the CONTRACTOR.

UnitedHealthcare agrees that any lost or reduced federal matching money resulting from unacceptable performance in a contractor task or responsibility defined in the RFP, contract or modification shall be accompanied by reductions in state payments to UnitedHealthcare.

l. The bidder has not been retained, nor has it retained a person to solicit or secure a state contract on an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except for retention of bona fide employees or bona fide established commercial selling agencies maintained by the bidder for the purpose of securing business. For breach of this provision, the State shall have the right to reject the bidder's proposal, terminate the CONTRACT for cause and/or deduct from the CONTRACT price or otherwise recover the full amount of such commission, percentage, brokerage, or contingent fee or other benefit.

UnitedHealthcare has not been retained, nor has it retained a person to solicit or secure a state contract on an agreement or understanding for a commission, percentage, brokerage or contingent fee.

January 3, 2024

To: Kansas Department of Health and Environment and Kansas Department for Aging
RE: KanCare Medicaid & CHIP Capitated Managed Care RFP EVT0009267
Transmittal Letter Section 4.3.C.1.j

Dear Sir/Madam:

UnitedHealthcare of the Midwest, Inc., as the Bidder and on behalf of itself and its affiliates, submits this written authorization pursuant to the requirement of Transmittal Letter Section 4.3.C.1.j of the *KanCare Medicaid & CHIP Capitated Managed Care RFP EVT0009267*.

Bidder confirms that its affiliates and/or subsidiaries providing direct services, supplies or equipment to comply with the performance requirements under the resulting contract of the RFP, agree to the audits rights identified in Transmittal Letter Section 4.3.C.1.j of the *KanCare Medicaid & CHIP Capitated Managed Care RFP EVT0009267.* As our ultimate parent company, UnitedHealth Group, is not providing direct services, supplies or equipment and is a publicly traded corporation. Any material matters including financial statements and SEC filings may be found on the UnitedHealth Group website: www.unitedhealthgroup.com.

Respectfully submitted,

Kevin Sparks
CEO, UnitedHealthcare Community Plan of Kansas

Executive Summary (Tab 3)

Personalized Support Helps Members Access Healthy Activities

Less than one-quarter of kids in the United States meet physical activity guidelines. We take a proactive approach to help Members access healthy activities in their neighborhood. Our teams provide personalized support to identify healthy activities that meet our Members' unique interests, from soccer leagues to at-home fitness kits. One Member shares how the program has helped her son become more active and engaged in their community.

Kansans United

United Healthcare Community Plan

Executive Summary (Tab 3)

1. Tab 3 must be labeled "Executive Summary" and contain the bidder's executive summary. The executive summary must include an overview of the bidder, its relevant experience, and a high-level description of its proposed approach to meeting RFP requirements. The executive summary is limited to a maximum of five (5) pages. The Executive Summary will not be scored, but it will be reviewed by the State during the evaluation process, and it may be used in whole or part by the State in public communication following award.

UnitedHealthcare Community Plan of Kansas (UnitedHealthcare) welcomes the opportunity to present our approach, experience, capabilities, strengths and the added value we continue to bring to the KanCare program.

As Kansans, we have been honored to serve our state and our communities. We have tried to live up to that honor by relentlessly pursuing quality and better health outcomes for our fellow Kansans. We believe the proof of our commitment and capabilities is in our results. ***Put simply, UnitedHealthcare is consistently rated the highest quality plan and is the plan Members choose the most*:**

- UnitedHealthcare has been ranked first in quality since 2014. In the most recent measurement year, we finished first in 77% (10 out of 13) Kansas Department of Health and Environment (KDHE) pay-for-performance measures.
- We are the top-rated KanCare managed care organization (MCO) in NCQA's Medicaid Health Plan Ratings 2023 for Patient Experience (4 out of 5), Getting Care Quickly (5 out of 5) and Satisfaction with Plan and Plan Services (4 out of 5), and we are rated 4 out of 5 overall.
- In addition to our long-standing status as the highest quality health plan, UnitedHealthcare is the plan Members choose most frequently, with more than 48% of Members who selected a plan choosing UnitedHealthcare.

We have achieved this position because we listen to Members and, based on their feedback, we work to serve them in better and more innovative ways. At the other end of every visit, benefits claim, authorization, click or call is a person, and our integrated whole-person care approach serves this important connection of physical, social and emotional health. In the following pages, we describe how we use partnerships, a commitment to quality and our capabilities to produce these results for our fellow Kansans.

UnitedHealthcare – The Trusted Partner in Kansas

The programs and services we provide stem from the voices and needs of KanCare Members, Providers and the communities we serve — fostering trust and **making us the number one choice of KanCare Members.** Through engaged listening and response and long-standing community partnerships, we continue to put Members — our neighbors — first.

Since 2013 and the inception of KanCare 1.0, UnitedHealthcare has been an integral partner in transforming health care in Kansas, and we continue to build and maintain genuine, consistent and authentic relationships with key community-based organizations (CBOs). With more than

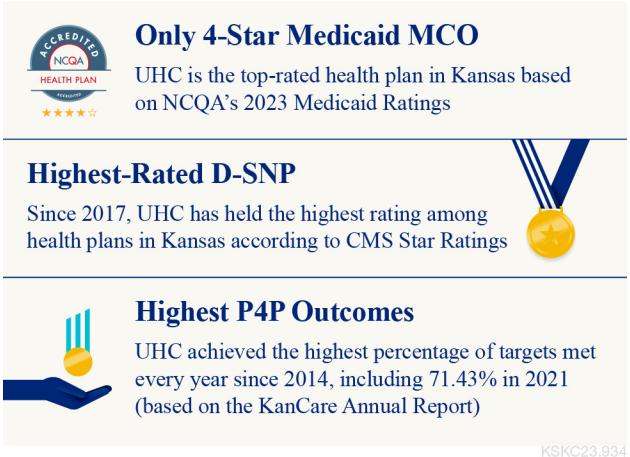
2,000 employees statewide and **more than 300 UnitedHealthcare team members dedicated fully to KanCare,** we are Kansans living and working in Kansas. At the heart of our community relationships are our local team of UnitedHealthcare staff who care about and are actively engaged in their communities — volunteering and partnering with local organizations serving rural, urban, faith-based, communities of color, people with disabilities and immigrants. In fact, **our employees volunteered approximately 32,000 hours in their Kansas communities in 2022,** and they have volunteered more than 18,000 hours in 2023.

With more than 21,400 Providers and 165 hospitals as partners, Kansans can get the care they need when they need it. Our team is committed to what works — our "Member in the Center" approach of listening, acting on what we learn, evaluating the results and constantly striving to improve to make the health care system work better for everyone.

Experience, Quality and Results

For the past decade, we approach our partnership through meaningful encounters, accountability and performance, exceeding State goals and consistently delivering better health outcomes. We have built a foundation of trust and experience with KDHE, Kansas Department for Aging and Disability Services (KDADS) and Department of Children and Families (DCF) by serving Temporary Assistance for Needy Families (TANF); CHIP; Foster; Aged, Blind and Disabled; and nursing home and home- and community-based services (HCBS) waiver populations that:

- Improves Member experiences and satisfaction
- Provides equitable, holistic care to Members that improves outcomes
- Reduces health disparities
- Expands the Kansas Provider network and direct care workforce
- Enhances the Provider experience
- Delivers cost-effective strategies to improve service delivery
- Promotes continuous quality improvement through data and innovation



We will continue to meet these State goals by advancing our localized "Member in the Center" approach of serving Kansans through our compassionate and personalized care, continued listening tour facilitation throughout the state and relentless focus on analyzing and driving effective Net Promoter Scores. **Our service to KanCare Members is rooted in and amplified by the fabric of our community, the health care Providers we partner with, our innovative supports and statewide team.** Our proposal aligns our solutions, core capabilities and guiding principles with the specific goals of the KanCare program, and we are committed to meeting the RFP requirements to effectively advance the State's vision and goals now and into the future.

The Core Capabilities of Our Approach to Meet RFP Requirements

Grounded in Kansas: Our statewide footprint supports a strong local infrastructure and workforce in Kansas communities. Our team understands and reflects the needs and values of Kansas communities because we are part of those

communities. KanCare Members and Providers see us as partners in the community — good people doing good things on and off the clock.

Our team's authenticity and our deep conviction to serve our Members not only foster trust in our quality care and build strong community relationships, but also yield solutions and key measurable impacts. For example, our internal and State-level data demonstrated that families living in Wyandotte County were at higher risk for negative birth and maternal health outcomes. We addressed these long-standing disparities affecting Black Members, Indigenous Members and People of Color in Wyandotte County by strengthening local Community Health Workers (CHWs) and their Tribal counterparts, Community Health Representatives (CHRs).

Transformative Commitment for KanCare

We will invest **$150,000** in a scholarship fund for the Kansas Community Health Worker Coalition to provide training and certification for CHWs.

We will provide **$80,000** to COPE to support its equity activities through 2024.

In 2016, we provided $1.6 million to the Community Health Council of Wyandotte County, and we are committed to transforming health care in Kansas through continued transformative commitments to strengthen what works. To support these trusted relationships, we funded one of the largest CHW programs for the State of Kansas, and we are seeing improved health literacy reported among Members, higher CHW retention rates and better prepared CHWs (100% have completed and earned their first of four badges in Health Equity Foundations).

Constant improvement: Our unyielding pursuit of improvement is driven by data, experiences and feedback, evaluation and analysis and enhanced health outcomes. Through data, analysis and continuous improvement, we support meaningful change such as:

- **Demonstrable improvements in birth outcomes:** As introduced previously, to address local disparities identified for Black infants requiring treatment from the NICU, we increased care management engagement and added doula support, which led to a year-over-year decrease in NICU rates:
  - Sedgwick County: 16.5% (2021) to 9.4% (2022)
  - Wyandotte County: 12.6% (2021) to 8.1% (2022)
- **Advancing value-based care:** We are relentless in our pursuit of continuous quality improvement and will continue to deploy and evolve our diverse suite of value-based purchasing programs. Our Community Plan Primary Care Professional Incentive (CP-PCPi) program has grown more than 300% since 2016 to 2022. [redacted]

Transformative Commitment for KanCare

We are excited to announce our **annual $1 million investment** designed to directly build out the HCBS ecosystem across the State.

Understanding the importance of partnership in supporting health, wellness, and independence for a healthier Kansas, we work with CBOs to strengthen resources and promote equitable access. To support equitable access, we focus on workforce

retention and capacity. For example, we are partnering with Overland Park-based Solvative to implement a new, shared statewide direct care worker (DCW) database tracking tool to empower effective and timely workforce monitoring, gap closure and corrective action plan (CAP) adherence. This partnership-focused solution will be available to all MCOs, DCWs, the State and key KanCare stakeholders.

Catalyzing connections: Our local engagement helps achieve the long-term goals of improving access to care, reducing health disparities, facilitating healthy behaviors, and enhancing public health funding and capacity. Not only do our investments into Kansas communities boost the local economy and foster a stronger sense of unity and progress, but they also stand people up when they need it the most. Our investments pave the way for improved health outcomes and increased financial stability of the organizations supported. Our commitment includes support for CBOs, such as faith-based organizations, food pantries, housing and employment organizations. Guided by our trusted community partners, we are catalysts — sparking innovation and building a community health infrastructure. The following table outlines a few examples of our recent and upcoming investments in Kansas aligned to State goals.

Investing in Kansas Communities	
State Goals	**Recent and Upcoming Investments**
Provide equitable, holistic care to Members that improves outcomes – postpartum care	▪ **Kansas Birth Justice Society ($30,000)** to support the Matrescence Center for parents/infants of color ▪ **Mothers in Medicine program ($50,000)** to provide childcare grants to clinical parents
Reduce health disparities	▪ **COPE ($80,000)** to support the Community Health Worker Program in 20 rural counties aimed at addressing social determinants of health (SDOH)
Expand the Kansas Provider network and direct care workforce	▪ **Kansas Association of Workforce Boards ($50,000)** to provide supports and training for job seekers ▪ **Wichita State University ($100,000)** Direct Service Worker Initiative (Sedgwick County)
Enhance the Provider experience	▪ **Finney County Community Health Coalition ($50,000)** to expand service education to Garden City on dangers of opioid overuse and to purchase and distribute naloxone ▪ **Kansas Statewide Homeless Coalition ($50,000)** to support a regional special projects coordinator role
Deliver cost-effective strategies to improve service delivery	▪ **Salina Family Health Center ($100,000)** to support their mobile medicine program
Improve Member experiences and satisfaction	▪ **Community Health Center of Southeast Kansas ($90,000)** to support health care and pharmacy entities that provide medications to uninsured and underinsured

Integrity driven: We uphold unwavering ethical standards and integrity at every level of our organization and are committed to building trusted and transparent relationships. As the preferred plan in Kansas, we are not always perfect, but we are always responsive. For the past 10 years of partnering with the KanCare program, when obstacles present themselves, we listen, respond and focus on a timely and responsive solution.

My why:
Kevin Sparks
President & CEO

"It has been a great honor having the opportunity to serve as CEO for the UnitedHealthcare Community Plan of Kansas in the state where I grew up (Emporia, Kansas), went to college (University of Kansas) and met my wife (Stefanie) and where we raised our two children – Nate and Natalie. What I am most proud of is the mission-driven culture of care and compassion that we have built, focusing on serving the needs of individuals and families to help them lead healthy, successful lives. Kansas is my home, and I am passionate about leading our team to proactively recognize problems, create appropriate solutions, analyze preventative measures to help fix the root cause of the problems and ultimately to serve our fellow Kansans in need. I am proud of the service excellence reputation we have built over the last ten years in the service of the KanCare program."

KSKC23.910

Recent feedback from State audits note that in helping Members navigate the complexities of health care, we **"thoroughly train our employees and keep them up to date and in full compliance."** We value feedback on our staff, including that staff is **"caring and easy to work with"** and focus on continued understanding and improvement. People coming together is the strength of our health plan, and we are committed to helping the State achieve its goals through our values and core capabilities. As an integrity-driven organization, we believe in doing exactly what we promise, providing innovative, community-focused and data-driven solutions to address the health inequities of Kansans. We leverage our strong partnerships and the power of technology to provide localized, Member-centric and compassionate care. Our vision is to advance this approach, incorporating quality improvement in all our operations, always aiming to exceed the State's expectations. Our path forward is a perfect complement to the Healthy People 2030 framework that informs the Kansas State Health Improvement Plan as we focus on stabilizing and increasing the direct care workforce, empowering Members, and improving health outcomes.

We appreciate the opportunity to share our approach throughout this response that positions UnitedHealthcare, KDHE, KDADS and DCF for continued success. Our response reflects our past accomplishments and outlines a course for continuous improvement through adaptability, commitment and innovation. Our compassionate, personalized care is supported through direct Member feedback, Provider collaboration and community partnerships. We bring our hearts to Kansans, and, partnering together, we maximize the opportunities of today and tomorrow to achieve health, wellness and independence for a healthier Kansas.

KANSAS COMMUNITY SUPPORT

"UnitedHealthcare has consistently proven to be an outstanding partner in our mission to provide person-centered care and support to those in need. One aspect that truly sets UnitedHealthcare apart is your unwavering focus on helping people transition from institutionalized care to their homes. Your genuine care and concern for the well-being of our clients have been evident in your collaborative approach and the personalized attention you provide."

– Janet Williams, CEO and founder, Minds Matter

Required Forms (Tab 4)

Increasing Access to Primary Care in Rural Neighborhoods

Rural communities experience barriers accessing primary care. We partnered with Salina Family Healthcare Center to deploy a new mobile health unit to serve Saline County and seven surrounding counties. The mobile unit is increasing outreach and availability of primary and preventive care services, with the goal of closing health disparities and gaps in care for people living in rural areas.

Kansans United

United Healthcare Community Plan

ATTACHMENT 2: SIGNATURE SHEET

Item: KanCare Medicaid & CHIP Capitated Managed Care
Agency: Kansas Department of Health and Environment (KDHE), Kansas Department for Aging and Disability Services (KDADS)
Closing Date: January 4, 2024, 2:00 PM CST

By submission of a bid and the signatures affixed thereto, the bidder certifies all products and services proposed in the bid meet or exceed all requirements of this specification as set forth in the request and that all exceptions are clearly identified.

UnitedHealthcare of the Midwest, Inc.
Legal Name of Person, Firm or Corporation

6860 W. 115th Street, Mail Route: KS015-M400
Mailing Address

Overland Park, KS
City & State

66211
Zip

1-877-542-9238
Toll Free Telephone

913-333-4068
Local Telephone

913-710-4293
Cell Phone

855-579-1061
Fax Number

43-1361841
Tax Number

CAUTION: If your tax number is the same as your Social Security Number (SSN), you must leave this line blank. DO NOT enter your SSN on this signature sheet. If your SSN is required to process a Contract award, including any tax clearance requirements, you will be contacted by an authorized representative of the Office of Procurement and Contracts at a later date.

Kevin_Sparks@uhc.com
E-Mail


Signature

11/30/2023
Date

Kevin Sparks
Typed Name

President & CEO
Title

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In the event the **contact for the bidding process** is different from above, indicate contact information below.

Tawnie Schubert
Bidding Process Contact Name

9800 Health Care Lane
Mailing Address

Minnetonka, MN
City & State

55343
Zip Code

N/A
Toll Free Telephone

N/A
Local Telephone

412-848-5618
Cell Phone

N/A
Fax Number

Tawnie.Schubert@uhc.com
E-Mail

If **awarded a CONTRACT and purchase orders** are to be directed to an address other than above, indicate mailing address and telephone number below.

N/A
Award Contact Name

N/A
Mailing Address

N/A
City & State

N/A
Zip Code

N/A
Toll Free Telephone

N/A
Local Telephone

N/A
Cell Phone

N/A
Fax Number

N/A
E-Mail

Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

UnitedHealthcare of the Midwest

DBA as UnitedHealthcare

ISSUE DATE
12/13/2023

TRANSACTION ID
T5YH-FMNP-MHTA

CONFIRMATION NUMBER
CFKP-HF3C-7S56

TAX CLEARANCE VALID THROUGH 03/12/2024

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

Tax Clearance Request Information

What is a Tax Clearance?

A Certificate of Tax Clearance is a comprehensive review to determine and ensure that the applicant's account is in current compliance with all applicable:

- Kansas tax laws administered by the director of taxation within the Kansas Department of Revenue.
- Taxes/fees/payments administered by the Kansas Department of Labor.
- Other various fees/charges administered by Kansas state agencies.

The status of, and information pertaining to a tax clearance is subject to change(s), which may arise as a result of a State Tax Audit, Federal Revenue Agent Report, or other lawful adjustment(s).

A State Tax Clearance should not be confused with a Letter of Good Standing which is an unrelated document issued by the Kansas Secretary of State's office.

Additional Tax Clearance Information

- Tax Clearance Frequently Asked Questions
- Tax Clearance Educational Brochure

Obtain a State of Kansas Tax Clearance

- Request Online - Click here to complete an application through our secure website. Return to the website the following day to retrieve your "Certificate of Tax Clearance". Applications must be submitted by 5pm Monday – Friday in order to be available the following business day.
- Click here to verify the validity of the "Certificate of Tax Clearance"
- **Special Event Tax Clearance** - If you are required to obtain a tax clearance for participation in a Special Event (fairs, racing events, shows, etc.) please complete the online application.
    - o International vendors and vendors who are not able to complete the online application must submit form CM-21. Email kdor_special.events@ks.gov or call the Special Events department at the number listed below to request a paper form.

Please Note:

- Tax clearance requests may be denied if the request is incomplete or incorrect information provided.
- All tax clearance requests must be submitted using the online application.

Tax Clearance information will only be released to the following:

Individual Information

- The individual taxpayer themselves.
- An individual who has notarized authorization from the taxpayer to request and receive tax information. (Please provide a copy. Cannot use online application.)
- An individual who has statutory authority or legal power of attorney to request and receive tax information for the taxpayer. (Please provide a copy. Cannot use online application.)
- Power of Attorney Form

Business Information

- The business owner
- A corporate officer, office manager, or other appointed official of the company
- An individual who has notarized authorization from the business owner or officer to request and receive tax information. (Please provide a copy. Cannot use online application.)
- An individual who has statutory authority or legal power of attorney to request and receive tax information on behalf of the business. (Please provide a copy. Cannot use online application.)

Any additional questions can be directed to:

Office Location

Scott State Office Building
120 SE 10th Avenue
Topeka, KS 66612-1103

Office Hours

8 a.m. to 4:30 p.m. Monday through Friday

Email:

kdor_specialprojects@ks.gov

Phone:

785-296-3199

Fax:

785-296-3655

Special Events

- 785-207-4972 - for Western Kansas events
- 785-207-1572 - for Eastern Kansas events
- Email kdor_special.events@ks.gov

EIN contains an invalid character.

Tax Clearance - Business Request

EIN:	41-1289245	00-0000000
Business Name:	UnitedHealthcare of the Midwest	
Doing Business As (DBA):	UnitedHealthcare	if different than Business Name
Individual Submitting this Request:	Christopher Gard	
Relationship or Authority:	Other	
Taxpayer's Email Address:	chris_gard@uhc.com	
Street 1:	6860 W 115th Street	
Street 2:		
City:	Overland Park	
State:	Kansas	
Zip Code:	66211	
Daytime Phone:	913-217-1757	000-000-0000
Daytime Phone Extension:		
Fax Number:		000-000-0000
Reason for Tax Clearance request:	Dept of Administration bid submission	

Does the business make retail sales in Kansas?	○ **Yes**	◉ **No**
Does the business have an office or retail outlet in Kansas?	◉ **Yes**	○ **No**
Does the business have employees in Kansas?	◉ **Yes**	○ **No**
Does the business have Kansas source income?	◉ **Yes**	○ **No**

Submission Verification and Agreement

☑ **By checking this box, I declare under penalties of perjury that, to the best of my knowledge and belief, the above information is true and correct.**

I'm not a robot reCAPTCHA Privacy - Terms

← Back Submit

Tax Clearance - Business Submission

Click here to print this information.

Your Transaction ID for this request is:

T5YH-FMNP-MHTA

This Transaction ID will be required to view your tax clearance status.

Your request for tax clearance was submitted on 12/12/2023
and will take approximately one business day to process.

If you provided an email address, you will receive an email containing this Transaction ID and a link back to this website to check your tax clearance status.

New Request | Exit

Tax Clearance Status

The request has been approved. Click here to view and print the certificate (opens a new window).

Enter the Tax ID Number (EIN or SSN):	41-1289245	00-0000000 or 000-00-0000
Enter the Transaction ID Number:	T4YC-3JD7-TRYC	T000-0000-0000

(Missing your Transaction ID? Email the Kansas Dept of Revenue at KDOR_SpecialProjects@ks.gov.)

← Back | Retrieve Status

ATTACHMENT 4: IMMIGRATION REFORM & CONTROL CERTIFICATION

CERTIFICATION REGARDING IMMIGRATION REFORM & CONTROL

All Contractors are expected to comply with the Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986, by the Contractor as well as any subcontractor or sub-subcontractor. The usual method of verification is through the Employment Verification (I-9) Form. With the submission of this bid, the Contractor hereby certifies without exception that Contractor has complied with all federal and state laws relating to immigration and reform. Any misrepresentation in this regard or any employment of persons not authorized to work in the United States constitutes a material breach and, at the State's option, may subject the contract to termination and any applicable damages.

Contractor certifies that, should it be awarded a contract by the State, Contractor will comply with all applicable federal and state laws, standards, orders and regulations affecting a person's participation and eligibility in any program or activity undertaken by the Contractor pursuant to this contract. Contractor further certifies that it will remain in compliance throughout the term of the contract.

At the State's request, Contractor is expected to produce to the State any documentation or other such evidence to verify Contractor's compliance with any provision, duty, certification, or the like under the contract.

Contractor agrees to include this Certification in contracts between itself and any subcontractors in connection with the services performed under this contract.

President & CEO

Signature, Title of Contractor

11/30/2023

Date

ATTACHMENT 5: POLICY REGARDING SEXUAL HARASSMENT

POLICY REGARDING SEXUAL HARASSMENT

WHEREAS, sexual harassment and retaliation for sexual harassment claims are unacceptable forms of discrimination that must not be tolerated in the workplace; and

WHEREAS, state and federal employment discrimination laws prohibit sexual harassment and retaliation in the workplace; and

WHEREAS, officers and employees of the State of Kansas are entitled to working conditions that are free from sexual harassment, discrimination, and retaliation; and

WHEREAS, the Governor and all officers and employees of the State of Kansas should seek to foster a culture that does not tolerate sexual harassment, retaliation, and unlawful discrimination.

NOW THEREFORE, pursuant to the authority vested in me as Governor of the State of Kansas, I hereby order as follows:

1. All Executive Branch department and agency heads shall have available, and shall regularly review and update at least every three years or more frequently as necessary, their sexual harassment, discrimination, and retaliation policies. Such policies shall include components for confidentiality and anonymous reporting, applicability to intern positions, and training policies.

2. All Executive Branch department and agency heads shall ensure that their employees, interns, and contractors have been notified of the state's policy against sexual harassment, discrimination, or retaliation, and shall further ensure that such persons are aware of the procedures for submitting a complaint of sexual harassment, discrimination, or retaliation, including an anonymous complaint.

3. Executive Branch departments and agencies shall annually require training seminars regarding the policy against sexual harassment, discrimination, or retaliation. All employees shall complete their initial training session pursuant to this order by the end of the current fiscal year.

4. Within ninety (90) days of this order, all Executive Branch employees, interns, and contractors under the jurisdiction of the Office of the Governor shall be provided a written copy of the policy against sexual harassment, discrimination, and retaliation, and they shall execute a document agreeing and acknowledging that they are aware of and will comply with the policy against sexual harassment, discrimination, and retaliation.

5. Matters involving any elected official, department or agency head, or any appointee of the Governor may be investigated by independent legal counsel.

6. The Office of the Governor will require annual mandatory training seminars for all staff, employees, and interns in the office regarding the policy against sexual harassment, discrimination, and retaliation, and shall maintain a record of attendance.

7. Allegations of sexual harassment, discrimination, or retaliation within the Office of the Governor will be investigated promptly, and violations of law or policy shall constitute grounds for disciplinary action, including dismissal.

8. This Order is intended to supplement existing laws and regulations concerning sexual harassment and discrimination, and shall not be interpreted to in any way diminish such laws and regulations. The Order provides conduct requirements for covered persons, and is not intended to create any new right or benefit enforceable against the State of Kansas.

9. Persons seeking to report violations of this Order, or guidance regarding the application or interpretation of this Order, may contact the Office of the Governor regarding such matters.

Agreement to Comply with the Policy Against Sexual Harassment, Discrimination, and Retaliation.

I hereby acknowledge that I have received a copy of the State of Kansas Policy Against Sexual Harassment, Discrimination, and Retaliation established by Executive Order 18-04 and agree to comply with the provisions of this policy.

11/30/2023

Signature and Date

Kevin Sparks

Printed Name

263

ATTACHMENT 6: BOYCOTT OF ISRAEL FORM

CERTIFICATION OF COMPANY NOT CURRENTLY ENGAGED IN A BOYCOTT OF GOODS OR SERVICES FROM ISRAEL

In accordance with HB 2482, 2018 Legislative Session, the State of Kansas shall not enter into a contract with a Company to acquire or dispose of goods or services with an aggregate price of more than $100,000, unless such Company submits a written certification that such Company is not currently engaged in a boycott of goods or services from Israel that constitutes an integral part of business conducted or sought to be conducted with the State.

As a Contractor entering into a contract with the State of Kansas, it is hereby certified that the Company listed below is not currently engaged in a boycott of Israel as set forth in HB 2482, 2018 Legislature.

President : CEO
Signature, Title of Contractor

11/30/2023
Date

Kevin Sparks
Printed Name

UnitedHealthcare of the Midwest, Inc.
Name of Company

STATE OF KANSAS
Event Details

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	1
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Event Description
State of Kansas

Kansas Department of Health and Environment
Kansas Department for Aging and Disability Services

General Comments

- **********
  0005 - Request for Proposal pursuant to K.S.A. 75-37,102

- **********
  Pre-proposal Conference - A mandatory pre-proposal conference will be held at 9:00 AM, on October 16, 2:00, via Zoom:

  Please see section 3.2.2 of the Bid documents, for Prebid instructions on how to receive call in information.

  Attendance is required for this pre-proposal conference. Failure to attend the pre-bid conference will result in rejection of your bid. Questions requesting clarification of the Bid Event must be submitted electronically (MS Word) to the Procurement Officer (Event Contact) indicated in the bidding instructions, prior to close of business on October 23, 2023. Impromptu questions may be permitted, and spontaneous unofficial answers provided, however bidders should understand that the only official answer or position of the State of Kansas will be presented in writing.

  Failure to notify the Procurement Officer (Event Contact) of any conflicts or ambiguities in the Bid Event may result in items being resolved in the best interest of the State. Any modification to this Bid Event as a result of the pre-proposal conference, as well as written answers to written questions, shall be made in writing by addendum and dispatched to all bidders associated to this event. Only written communications are binding.

  Answers to questions will be available in the form of an addendum on the Procurement and Contracts' website, http://admin.ks.gov/offices/procurement-contracts

  It shall be the responsibility of all participating bidders to acquire any and all addenda and additional information as it is made available from the web site cited above. Vendors/Bidders not initially invited to participate in this Bid Event must notify the Procurement Officer (Event Contact) of their intent to bid at least 24 hours prior to the event's closing date/time. Bidders are required to check the website periodically for any additional information or instructions.

- **********
  0008 - Invitation for Bid

- **********
  BIDDER MUST OBTAIN A CURRENT TAX CLEARANCE CERTIFICATE
  A “Tax Clearance” is a comprehensive tax account review to determine and ensure that the account is compliant with all primary Kansas Tax Laws administered by the Kansas Department of Revenue (KDOR) Director of Taxation. Information pertaining to a Tax Clearance is subject to change(s), which may arise as a result of a State Tax Audit, Federal Revenue Agent Report, or other lawful adjustment(s).

  INSTRUCTIONS: To obtain a Current Tax Clearance Certificate, you must:
  • Go to http://ksrevenue.org/taxclearance.html to request a Tax Clearance Certificate
  • Return to the website the following working day to see if KDOR will issue the certificate
  • If issued an official certificate, print it and attach it to your bid response
  • If denied a certificate, engage KDOR in a discussion about why a certificate wasn’t issued

  Bidders (and their subcontractors) are expected to submit a current Tax Clearance Certificate with every event response.

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	2
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

REMINDER: You will need to sign back into the KDOR website to view and print the official tax clearance certificate.

Information about Tax Registration can be found at the following website:
http://www.ksrevenue.org/busregistration.html

Procurement and Contracts reserves the right to confirm tax status of all potential contractors and subcontractors prior to the release of a purchase order or contract award.

In the event that a current tax certificate is unavailable, Procurement and Contracts reserves the right to notify a bidder (one that has submitted a timely event response) that they have to provide a current Tax Clearance Certificate within ten (10) calendar days, or Procurement and Contracts may proceed with an award to the next lowest responsive bidder, whichever is determined by the Director of Purchases to be in the best interest of the State.

- **********
The State of Kansas, as a matter of public policy, encourages anyone doing business with the State of Kansas to take steps to discourage human trafficking. If prospective bidders/vendors/Contractors have any policies or participate in any initiatives that discourage human trafficking the prospective bidder/vendor/Contractor is encouraged to submit same as part of their bid response.

- **********
During the 2012 Session, the Kansas Legislature enacted a Bidder Preference Program which created three (3) bid preferences. To see if you qualify for any of the preferences, please go to the following website for more information:
https://admin.ks.gov/offices/procurement-contracts/bidding--contracts/bidder-programs/certified-business-and-disabled-veteran-owned-business.

To claim this preference, the bid response must include the Preference Request Form and you must respond to the applicable Bidder Preference category in the question under the General Questions section on the following page(s).

****
During the 2014 Session, the Kansas Legislature enacted the Disabled Veteran Owned Business bidder preference program. For more information or to see if you qualify, please go to the following website:
https://admin.ks.gov/offices/procurement-contracts/bidding--contracts/bidder-programs/bidder-preference-program

To claim this preference, the bid response must include a copy of the letter from Procurement and Contracts certifying your company as a Disabled Veteran Owned Business and you must respond to the applicable Disabled Veteran Owned Business category in the question under the General Questions section on the following page(s).

General Questions

Question	UOM	Best	Worst	Response
Please select ONE category from the following list with regard to a Bidder Preference. If selecting a Bidder Preference category, supporting documentation must accompany this bid response. (Note: #3 "State Use Purchases" category does not apply to Requests for Proposals)				**Select One**
Options: Not claiming any Bidder Preference Category				X
Claiming the Disabled Veteran Owned Business Category				
Claiming the State Use Purchases Bidder Preference Category				
Claiming the Certified Business Bidder Preference Category				

Required: Yes Mandatory Response: No

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	3
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Response Comments

N/A

Is a completed Boycott of Israel form included with your bid event submission?

Yes

Required: Yes Mandatory Response: No

Response Comments

N/A

Is a completed Sexual Harassment form included with your bid event submission?

Yes

Required: Yes Mandatory Response: No

Response Comments

By signing the Policy Regarding Sexual Harassment, UnitedHealthcare of the Midwest, Inc. acknowledges that it received a written copy of the Policy Regarding Sexual Harassment, and to the extent applicable, agrees to comply with the Contractor terms in the Policy Regarding Sexual Harassment. UnitedHealthcare of the Midwest, Inc. maintains written sexual harassment, non-discrimination, and non-retaliation policies, training, and complaint and investigation procedures that apply to its employees.

Is a completed Immigration Reform and Control form included with this bid event submission (refer to Appendix B - Terms and Conditions, Event Details document)?

Yes

Required: Yes Mandatory Response: No

Response Comments

N/A

Does your organization accept the State of Kansas terms and conditions as stated?

Yes

Required: Yes Mandatory Response: No

Response Comments

N/A

Is a current Tax Clearance Certificate included with this bid event submission (refer to Appendix B - Terms and Conditions, Event Details document)?

Yes

Required: Yes Mandatory Response: No

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	4
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States

Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Response Comments

N/A

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	5
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States

Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Line Details

No Bid: ☐

Line: 1 **Item ID:** **Line Qty:** 1.00 **UOM:** Each **Bid Qty:**
Required: No **Reserve Price:** No
Min/Max Qty: No min / No max

Description: KanCare Medicaid and CHIP Capitated Managed Care Services

Question	UOM	Best	Worst	Response
What is your bid price?				$921.50 PMPM

Required: Yes Mandatory Response: No

Response Comments

N/A

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	6
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Bidder Information

Firm Name: UnitedHealthcare of the Midwest, Inc.

Name: Kevin Sparks **Signature:**  **Date:** 12/06/2023

Phone #: 913-333-4068 **Fax #:** 855-579-1061

Street Address: 6860 W. 115th Street, Mail Route: KS015-M400

City & State: Overland Park, KS **Zip Code:** 66211

Email: Kevin_Sparks@uhc.com

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	7
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States

Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Appendix A - Line Specifications

Line: 1 **Item ID:** **Line Qty:** 1 **UOM:** Each
Description: KanCare Medicaid and CHIP Capitated Managed Care Services

Item Specifications

Manufacturer:			
Mfg Item ID:			
Item Length:	0	**Item Height:**	0
Item Width:	0	**Dimension UOM:**	
Item Volume:	0	**Volume UOM:**	
Item Weight:	0	**Weight UOM:**	
Item Size:		**Item Color:**	

Shipping Information

Schedule:	1	**Ship To:**	Procurement and Contracts
Quantity:	1		Procurement and Contracts
Due Date:	01/09/2024		900 SW Jackson
Freight Terms:			Suite 451 South
Ship Via:			Topeka KS 66612
			United States

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	8
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Appendix B - Terms & Conditions

1. It is the bidder's responsibility to submit questions, acknowledge addenda and attend pre-bid conferences as indicated in this event or attachment(s). When communicating always refer to the Bid Event ID.

2. Conflict of Interest: With the submission of a response for this bidding event, you certify that you do not have any substantial conflict of interest sufficient to influence the bidding process of this event. A conflict of substantial interest is one which a reasonable person would think would compromise the opening bidding process.

3. BIDDER MUST OBTAIN A CURRENT TAX CLEARANCE CERTIFICATE A "Tax Clearance" is a comprehensive tax account review to determine and ensure that the account is compliant with all primary Kansas Tax Laws administered by the Kansas Department of Revenue (KDOR) Director of Taxation. Information pertaining to a Tax Clearance is subject to change(s), which may arise as a result of a State Tax Audit, Federal Revenue Agent Report, or other lawful adjustment(s). INSTRUCTIONS: To obtain a Current Tax Clearance Certificate, you must: 1) Go to: http://ksrevenue.org/taxclearance.html to request a Tax Clearance Certificate; 2) Return to the website the following working day to see if KDOR will issue the certificate; 3) If issued an official certificate, print it and attach it to your bid response; and 4) If denied a certificate, engage KDOR in a discussion about why a certificate wasn't issued. Bidders (and their subcontractors) are expected to submit a current Tax Clearance Certificate with every event response. REMINDER: You will need to sign back into the KDOR website to view and print the official tax clearance certificate. Information about Tax Registration can be found at the following website:
http://www.ksrevenue.org/busregistration.html. Procurement and Contracts reserves the right to confirm tax status of all potential contractors and subcontractors prior to the release of a purchase order or contract award. In the event that a current tax certificate is unavailable, Procurement and Contracts reserves the right to notify a bidder (one that has submitted a timely event response) that they have to provide a current Tax Clearance Certificate within ten (10) calendar days, or Procurement and Contracts may proceed with an award to the next lowest responsive bidder, whichever is determined by the Director of Purchases to be in the best interest of the State.

4. Immigration and Reform Control Act of 1986 (IRCA): All contractors are expected to comply with the Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986, by the contractor as well as any subcontractor or sub-contractors. The usual method of verification is through the Employment Verification (I-9) form. With the submission of this bid, the contractor hereby certifies without exception that such contractor has complied with all federal and state laws relating to immigration and reform. Any misrepresentation in this regard or any employment of persons not authorized to work in the United States constitutes a material breach and, at the State's option, may subject the contract to termination for cause and any applicable damages. Unless provided otherwise herein, all contractors are expected to be able to produce for the State any documentation or other such evidence to verify Contractor's IRCA compliance with any provision, duty, certification, or like item under the contract.
Bidders must submit a Certification Regarding Immigration Reform and Control form with every event response. The form can be found at the following website:
http://www.admin.ks.gov/docs/default-source/ofpm/procurement-contracts/irca.doc.

5. Competition: The purpose of this Request is to seek competition. The bidder shall advise Procurement and Contracts if any specification, language or other requirement inadvertently restricts or limits bidding to a single source. Notification shall be in writing and must be received by Procurement and Contracts no later than five (5) business days prior to the event closing date. The Director of Purchases reserves the right to waive minor deviations in the specifications which do not hinder the intent of this Request.

6. Acceptance or Rejection: The State reserves the right to accept or reject any or all bid responses or part of a response; to waive any informalities or technicalities; clarify any ambiguities in responses; modify any criteria in this Event; and unless otherwise specified, to accept any item in a response.

7. Disclosure of Bid Event Content and Proprietary Information: All bid responses become the property of the State of Kansas. The Kansas Open Records Act (K.S.A. 45-215 et seq) requires public information be placed in the public domain at the conclusion of the selection process, and be available for examination by all interested parties. More information on this subject can be found at the following website:
http://admin.ks.gov/offices/chief-counsel/kansas-open-records-act.

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	9
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: **PUBLIC EVENT DETAILS**

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

8. Debarment of State Contractors. Any Contractor who defaults on delivery or does not perform in a satisfactory manner as defined in this Agreement may be barred for a period up to three (3) years, pursuant to K.S.A. 75-37,103, or have its work evaluated for pre-qualification purposes. Contractor shall disclose any conviction or judgment for a criminal or civil offense of any employee, individual or entity which controls a company or organization or will perform work under this Agreement that indicates a lack of business integrity or business honesty. This includes (1) conviction of a criminal offense as an incident to obtaining or attempting to obtain a public or private contract or subcontract or in the performance of such contract or subcontract; (2) conviction under state or federal statutes of embezzlement, theft, forgery, bribery, falsification or destruction of records, or receiving stolen property; (3) conviction under state or federal antitrust statutes; and (4) any other offense the State determines to be so serious and compelling as to affect responsibility as a state contractor. For the purpose of this section, an individual or entity shall be presumed to have control of a company or organization if the individual or entity directly or indirectly, or acting in concert with one or more individuals or entities, owns or controls twenty-five (25) percent or more of its equity, or otherwise controls its management or policies. Failure to disclose an offense may result in disqualification of the Proposal or termination of the Agreement, as determined by the State.

9. Accounts Receivable Set-Off Program: If during the course of this contract the Contractor is found to owe a debt to the State of Kansas, agency payments to the Contractor may be intercepted / setoff by the State of Kansas. Notice of the setoff action will be provided to the Contractor. Pursuant to K.S.A. 75-6201 et seq, Contractor shall have the opportunity to challenge the validity of the debt. If the debt is undisputed, the Contractor shall credit the account of the agency making the payment in an amount equal to the funds intercepted. K.S.A. 75-6201 et seq. allows the Director of Accounts and Reports to set off funds the State of Kansas owes Contractors against debts owed by the contractor to the State of Kansas. Payments set off in this manner constitute lawful payment for services or goods received. The Contractor benefits fully from the payment because its obligation to the State is reduced by the amount subject to setoff.

Last Updated: 01/24/2019

Office of Procurement and Contracts
900 SW Jackson St., Room 451 South
Topeka, KS 66612

Kansas
Department of Administration

Phone: 785-296-2376
Fax: 785-296-7240
https://admin.ks.gov/offices/procurement-contracts

Adam Proffitt, Secretary
Todd Herman, Director

Laura Kelly, Governor

AMENDMENT

Date:	October 20, 2023
Amendment Number:	1
RFP Number:	EVT0009267
Closing Date:	January 4, 2024, 2:00 PM
Procurement Officer: **Telephone:** **E-Mail Address:** **Web Address:**	Amanda Acuna 785-296-5419 Amanda.Acuna@ks.gov http://admin.ks.gov/offices/procurement-and-contracts/
Agency:	Kansas Department of Health and Environment (KDHE), Kansas Department for Aging and Disability Services (KDADS)
Item:	KanCare Medicaid & CHIP Capitated Managed Care

Conditions:

1. The deadline for submitting written questions requesting clarifications has been extended to October 27, 2023, by 12 p.m. CT to allow adequate time for review and response.

2. Technical issues were experienced with the following two folders in the KanCare Bidder's Library and have since been resolved.
   a. De-Identified Claims Data
   b. EDI Companion Guides

A signed copy of this Addendum must be submitted with your bid. If your bid response has been returned, submit this Addendum by the closing date indicated above.

I (We) have read and understand this addendum and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: UnitedHealthcare of the Midwest, Inc.

SIGNED BY: _____

TITLE: President & CEO DATE: 11/30/2023

It shall be the vendor's responsibility to monitor this website on a regular basis for any changes/addenda.
http://admin.ks.gov/offices/procurement-and-contract

Office of Procurement and Contracts
900 SW Jackson St., Room 451 South
Topeka, KS 66612

Adam Proffitt, Secretary
Todd Herman, Director

Kansas
Department of Administration

Phone: 785-296-2376
Fax: 785-296-7240
https://admin.ks.gov/offices/procurement-contracts

Laura Kelly, Governor

AMENDMENT

Date:	November 28, 2023
Amendment Number:	2
RFP Number:	EVT0009267
Closing Date:	January 4, 2024, 2:00 PM
Procurement Officer: **Telephone:** **E-Mail Address:** **Web Address:**	Amanda Acuna 785-296-5419 Amanda.Acuna@ks.gov http://admin.ks.gov/offices/procurement-and-contracts/
Agency:	Kansas Department of Health and Environment (KDHE), Kansas Department for Aging and Disability Services (KDADS)
Item:	KanCare Medicaid & CHIP Capitated Managed Care

Conditions: See response to questions and changes to RFP language below.

A signed copy of this Addendum must be submitted with your bid. If your bid response has been returned, submit this Addendum by the closing date indicated above.

I (We) have read and understand this addendum and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: UnitedHealthcare of the Midwest, Inc.

SIGNED BY: _____

TITLE: President & CEO DATE: 11/30/2023

It shall be the vendor's responsibility to monitor this website on a regular basis for any changes/addenda.
http://admin.ks.gov/offices/procurement-and-contract

Evidence of Certificate of Authority (Tab 5)

Partnering to Improve Mobility Through Local Resources and Events

We partner with organizations that meet local community needs. Through a grant from UnitedHealthcare, Bike Walk Wichita has supported thousands of people from underserved communities, including recently resettled refugees, students experiencing homelessness and the LGBTQ+ community, to live healthier and more active lives with free biking equipment and events that highlight community-based resources.

Kansans United

United Healthcare Community Plan

STATE OF KANSAS

INSURANCE DEPARTMENT

CERTIFICATE OF AUTHORITY

Amended

UnitedHealthcare of the Midwest, Inc.

a corporation organized under the laws of Missouri

with principal office at Maryland Heights, Missouri

has complied with all the requirements of the insurance laws of this state applicable to said organization, and the said organization is hereby authorized and empowered to transact the following business, to wit:

HEALTH MAINTENANCE ORGANIZATION

within the State of Kansas from the 7th day of February, 1995, until such certificate is suspended or revoked by the Commissioner of Insurance.

In Witness Whereof, I, SANDY PRAEGER, Commissioner of Insurance of Kansas, have hereunto affixed my signature and the seal of the Commissioner of Insurance, in the city of Topeka, Kansas, this 26th day of March, 2009.

Sandy Praeger

Commissioner of Insurance

Kansas Insurance Department

Sandy Praeger, Commissioner of Insurance

March 26, 2009

Ms. Judy Bass
Regulatory Affairs
UnitedHealthcare
13665 Riverport Drive
PO Box 2560
Mail Route MO050-1000
Maryland Heights, MO 63043-8560

Dear Ms. Bass:

Please find enclosed an amended Certificate of Authority which was issued today authorizing UnitedHealthcare of the Midwest, Inc. to transact the business of a health maintenance organization in the State of Kansas.

Any technical details relating to your Certificate of Authority to transact business here will be forthcoming under separate cover.

Sincerely,

Jay J. Rogers
Accident & Health Division

JJR:ch
Enclosure

cc: Christine Rexford

Legal & Reg Affairs
RECEIVED
MAR 30 2009

420 SW 9th Street
Topeka, Kansas 66612-1678

785-296-3071 Phone
785-296-2283 Fax

Consumer Hotline
800-432-2484

Website
www.ksinsurance.org

Financial Viability/ Solvency (Tab 6)

Supporting a Strong and Diverse Doula Workforce

Kansas reports a higher rate of maternal deaths compared to the national average. Doula care can make a difference in maternal and child health outcomes through nonclinical support before, during and after birth. UnitedHealthcare collaborated with The Doula Network to create 20 scholarships for doulas to become certified. The scholarships aim to increase the capacity and diversity of the doula workforce serving Kansas.

Kansans United

United Healthcare Community Plan

Financial Viability/Solvency (Tab 6)

Audited Financial Statements

Parent Company Audited Financial Statements

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UnitedHealthcare of the Midwest, Inc. – 2022

Audited Financial Statements

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UnitedHealthcare of the Midwest, Inc.

Statutory Basis Financial Statements as of and for the Years Ended December 31, 2022 and 2021, Supplemental Schedules as of and for the Year Ended December 31, 2022, Independent Auditor's Report and Qualification Letter

UNITEDHEALTHCARE OF THE MIDWEST, INC.

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50 South 6th Street
Suite 2800
Minneapolis, MN 55402-1538
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INDEPENDENT AUDITOR'S REPORT

To the Audit Committee of
UnitedHealthcare of the Midwest, Inc.
13655 Riverport Drive, MO050-1000
Maryland Heights, MO 63043

Opinion

We have audited the statutory basis financial statements of UnitedHealthcare of the Midwest, Inc. (the "Company"), which comprise the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2022 and 2021, and the related statutory basis statements of operations, changes in capital and surplus, and cash flows for the years then ended, and the related notes to the statutory basis financial statements (collectively referred to as the "statutory basis financial statements").

In our opinion, the accompanying statutory basis financial statements present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus of the Company as of December 31, 2022 and 2021, and the results of its operations and its cash flows for the years then ended in accordance with the accounting practices prescribed or permitted by the Missouri Department of Insurance described in Note 1.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Statutory Basis Financial Statements section of our report. We are required to be independent of the Company, and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Statutory Basis of Accounting

We draw attention to Note 1 of the statutory basis financial statements, which describes the basis of accounting. As described in Note 1 to the statutory basis financial statements, the statutory basis financial statements are prepared by the Company using accounting practices prescribed or permitted by the Missouri Department of Insurance, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to meet the requirements of the Missouri Department of Insurance. As a result, the statutory basis financial statements may not be suitable for another purpose. Our opinion is not modified with respect to this matter.

Responsibilities of Management for the Statutory Basis Financial Statements

Management is responsible for the preparation and fair presentation of the statutory basis financial statements in accordance with the accounting practices prescribed or permitted by the Missouri Department of Insurance. Management is also responsible for the design, implementation, and

maintenance of internal control relevant to the preparation and fair presentation of statutory basis financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the statutory basis financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date that the statutory basis financial statements are issued.

Auditor's Responsibilities for the Audit of the Statutory Basis Financial Statements

Our objectives are to obtain reasonable assurance about whether the statutory basis financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the statutory basis financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the statutory basis financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the statutory basis financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the statutory basis financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Report on Supplemental Schedules

Our 2022 audit was conducted for the purpose of forming an opinion on the 2022 statutory basis financial statements as a whole. The supplemental investment risks interrogatories and the summary investment schedule as of and for the year ended December 31, 2022 are presented for purposes of

additional analysis and are not a required part of the 2022 statutory basis financial statements. These schedules are the responsibility of the Company's management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory basis financial statements. Such schedules have been subjected to the auditing procedures applied in our audit of the 2022 statutory basis financial statements and certain additional procedures, including comparing and reconciling such schedules directly to the underlying accounting and other records used to prepare the statutory basis financial statements or to the statutory basis financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such schedules are fairly stated in all material respects in relation to the 2022 statutory basis financial statements as a whole.

Restriction on Use

Our report is intended solely for the information and use of the Audit Committee and the management of the Company and for filing with state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte & Touche LLP

May 11, 2023

UNITEDHEALTHCARE OF THE MIDWEST, INC.

STATUTORY BASIS STATEMENTS OF ADMITTED ASSETS, LIABILITIES, AND CAPITAL AND SURPLUS AS OF DECEMBER 31, 2022 AND 2021

	2022	2021
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$ 50,800,229	$ 51,206,078
Cash of $51,335 and $253,849 and cash equivalents of $56,296,904 and $57,799,537, in 2022 and 2021, respectively	56,348,239	58,053,386
Subtotal cash and invested assets	107,148,468	109,259,464
OTHER ASSETS:		
Investment income due and accrued	681,231	379,658
Premiums and considerations	388,129,432	273,310,031
Amounts recoverable from reinsurers	132,443,356	92,826,846
Other amounts receivable under reinsurance contracts	17,535,151	15,885,403
Amounts receivable relating to uninsured plans	20,085,549	39,672,386
Net deferred tax asset	2,895,247	1,697,772
Health care receivables	48,558,788	58,674,479
Other assets	60	-
Subtotal other assets	610,328,814	482,446,575
TOTAL ADMITTED ASSETS	$ 717,477,282	$ 591,706,039
LIABILITIES, CAPITAL AND SURPLUS		
LIABILITIES:		
Claims unpaid	$ 135,014,322	$ 85,938,855
Accrued medical incentive pool and bonus amounts	4,631,594	2,315,738
Unpaid claims adjustment expenses	3,897,375	2,431,339
Aggregate health policy reserves, including $0 and $4,287,662 for medical loss ratio rebate per the Public Health Service Act for 2022 and 2021, respectively	69,948,641	44,766,631
Aggregate health claim reserves	1,490,628	976,708
Premiums received in advance	105	123
General expenses due or accrued	7,391,985	5,107,080
Current federal income tax payable	1,282,195	2,287,104
Ceded reinsurance premiums payable	167,177,462	126,996,959
Remittances and items not allocated	4,256	9,325
Amounts due to parent, subsidiaries, and affiliates	8,557,309	16,647,481
Liability for amounts held under uninsured plans	-	1,149,255
Other liabilities	879	6,984
Total liabilities	399,396,751	288,633,582
CAPITAL AND SURPLUS:		
Common capital stock, $1 par value — 100 shares authorized; 1 share issued and outstanding	1	1
Gross paid-in and contributed surplus	32,788,535	32,788,535
Unassigned surplus	285,291,995	270,283,921
Total capital and surplus	318,080,531	303,072,457
TOTAL LIABILITIES, CAPITAL AND SURPLUS	$ 717,477,282	$ 591,706,039

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDWEST, INC.

STATUTORY BASIS STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2022 AND 2021

	2022	2021
REVENUES:		
Net premium income	$ 2,262,866,553	$ 2,045,777,271
Change in reserve for rate credits	(26,008,270)	(265,251)
Total revenues	2,236,858,283	2,045,512,020
UNDERWRITING DEDUCTIONS:		
Hospital and medical:		
Hospital/medical benefits	2,897,629,025	2,492,828,718
Other professional services	108,788,305	73,391,605
Prescription drugs	216,889,842	203,594,773
Incentive pool, withhold adjustments, and bonus amounts	17,312,777	5,540,257
Net reinsurance recoveries	(1,387,801,902)	(1,087,369,469)
Total hospital and medical	1,852,818,047	1,687,985,884
Claims adjustment expenses	57,202,281	60,864,494
General administrative expenses	135,370,748	131,001,625
Increase in reserves for accident and health contracts	-	1,889
Total underwriting deductions	2,045,391,076	1,879,853,892
NET UNDERWRITING GAIN	191,467,207	165,658,128
NET INVESTMENT GAINS:		
Net investment income earned	3,562,478	1,248,000
Net realized capital gains less capital gains tax of $91 and $37,111 in 2022 and 2021, respectively	340	139,607
Total net investment gains	3,562,818	1,387,607
NET GAIN FROM AGENTS' OR PREMIUM BALANCES CHARGED OFF	11,326	17,639
OTHER LOSSES	(159,665)	(133,987)
NET INCOME BEFORE FEDERAL INCOME TAXES	194,881,686	166,929,387
FEDERAL INCOME TAXES INCURRED	41,052,105	34,874,994
NET INCOME	$ 153,829,581	$ 132,054,393

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDWEST, INC.

STATUTORY BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2022 AND 2021

	Common Capital Stock		Gross Paid-In and Contributed Surplus	Unassigned Surplus	Total Capital and Surplus
	Shares	Amount			
BALANCE — January 1, 2021	1	$ 1	$ 32,788,535	$ 223,635,986	$ 256,424,522
Net income	-	-	-	132,054,393	132,054,393
Change in net deferred income taxes	-	-	-	(53,400)	(53,400)
Change in nonadmitted assets	-	-	-	(353,058)	(353,058)
Cash dividends to parent	-	-	-	(85,000,000)	(85,000,000)
BALANCE — December 31, 2021	1	1	32,788,535	270,283,921	303,072,457
Net income	-	-	-	153,829,581	153,829,581
Change in net deferred income taxes	-	-	-	1,197,475	1,197,475
Change in nonadmitted assets	-	-	-	(5,018,982)	(5,018,982)
Cash dividends to parent	-	-	-	(135,000,000)	(135,000,000)
BALANCE — December 31, 2022	1	$ 1	$ 32,788,535	$ 285,291,995	$ 318,080,531

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDWEST, INC.

STATUTORY BASIS STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2022 AND 2021

	2022	2021
CASH FLOWS FROM OPERATIONS:		
Premiums collected, net of reinsurance	$ 2,187,401,703	$ 2,018,022,476
Net investment income	3,630,026	1,732,722
Benefit and loss related payments	(1,835,464,999)	(1,750,055,695)
Commissions and other expenses paid	(172,166,379)	(223,161,915)
Federal income taxes paid, net	(42,057,105)	(31,030,741)
Net cash provided by operations	141,343,246	15,506,847
CASH FLOWS FROM INVESTMENTS:		
Proceeds from investments sold, matured or repaid:		
Bonds	6,532,915	8,956,625
Total investment proceeds	6,532,915	8,956,625
Cost of investments acquired:		
Bonds	(6,496,959)	(8,383,537)
Total investments acquired	(6,496,959)	(8,383,537)
Net cash provided by investments	35,956	573,088
CASH FLOWS FROM FINANCING AND MISCELLANEOUS ACTIVITIES:		
Cash used in net transfers to affiliates	(8,090,172)	(1,531,126)
Dividends paid	(135,000,000)	(85,000,000)
Other cash provided	5,823	23,967
Net cash used in financing and miscellaneous activities	(143,084,349)	(86,507,159)
RECONCILIATION OF CASH AND CASH EQUIVALENTS:		
NET CHANGE IN CASH AND CASH EQUIVALENTS	(1,705,147)	(70,427,224)
CASH AND CASH EQUIVALENTS — Beginning of year	58,053,386	128,480,610
CASH AND CASH EQUIVALENTS — End of year	$ 56,348,239	$ 58,053,386

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDWEST, INC.

NOTES TO STATUTORY BASIS FINANCIAL STATEMENTS
AS OF AND FOR THE YEARS ENDED DECEMBER 31, 2022 AND 2021

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GOING CONCERN

Organization and Operation

UnitedHealthcare of the Midwest, Inc. (the "Company"), licensed as a health maintenance organization ("HMO"), offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. The Company is a wholly owned subsidiary of UnitedHealthcare, Inc. ("UHC"). UHC is a wholly owned subsidiary of United HealthCare Services, Inc. ("UHS"), a management corporation that provides services to the Company under the terms of a management agreement (the "Agreement"). UHS is a wholly owned subsidiary of UnitedHealth Group Incorporated ("UnitedHealth Group"). UnitedHealth Group is a publicly held company trading on the New York Stock Exchange.

The Company was incorporated on February 26, 1985, as an HMO and operations commenced in August 1985. The Company is certified as an HMO by the Missouri Department of Insurance (the "Department"). The Company has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees. As of December 31, 2022, the Company is licensed in five states.

The Company offers comprehensive commercial products to individuals. Each contract outlines the coverage provided and renewal provisions.

The Company serves as a plan sponsor offering a Dual Special Needs Plan (the "Medicare Plan") under a contract with the Centers for Medicare and Medicaid Services ("CMS").

The Company has a contract with the State of Kansas Department of Health and Environment ("KDHE" or "KanCare"), to provide health care services to Medicaid and Children's Health Insurance Program ("CHIP", a program for uninsured children) eligible beneficiaries in Kansas. The current contract is effective through December 31, 2023.

The Company has a contract with the State of Missouri Department of Social Services, Missouri HealthNet Division ("HealthNet"), to provide health care services to Medicaid and CHIP eligible beneficiaries in Missouri. The current contract is effective through June 30, 2023 and is subject to annual renewal provisions thereafter.

A. Accounting Practices

The statutory basis financial statements (herein referred to as "financial statements") are presented on the basis of accounting practices prescribed or permitted by the Department.

The Department recognizes only statutory accounting practices, prescribed or permitted by the State of Missouri (the "State"), for determining and reporting the financial condition and results of operations of an HMO, for determining its solvency under Missouri Insurance Law. The State prescribes the use of the National Association of Insurance Commissioners' ("NAIC") Accounting Practices and Procedures manual ("NAIC SAP") in effect for the accounting periods covered in the financial statements.

The Department has adopted certain prescribed accounting practices that differ from those found in the NAIC SAP. A reconciliation of the Company's net income and capital and surplus between the NAIC SAP and practices prescribed by the Department is shown below:

	SSAP #	AFS Line Desc	December 31, 2022	December 31, 2021
Net Income				
(1) Company state basis	XXX	XXX	$ 153,829,581	$ 132,054,393
(2) State prescribed practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(3) State permitted practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	XXX	XXX	$ 153,829,581	$ 132,054,393
Capital and Surplus				
(5) Company state basis	XXX	XXX	$ 318,080,531	$ 303,072,457
(6) State prescribed practices that are an increase/(decrease) from NAIC SAP: 20 CSR 200-1.040(3)(b) — Nonadmit prepaid premium taxes	101	Prepaid premium taxes	-	(7,241)
(7) State permitted practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(8) NAIC SAP (5 - 6 - 7 = 8)	XXX	XXX	$ 318,080,531	$ 303,079,698

Prepaid premium taxes of $0 and $7,241 as of December 31, 2022 and 2021, respectively, are required to be nonadmitted per Missouri Regulation 20 CSR 200-01.040. There was no impact to net income and no regulatory risk-based capital ("RBC") event was triggered from the Company using the Missouri statute.

B. Use of Estimates in the Preparation of the Financial Statements

The preparation of these financial statements in conformity with the NAIC Annual Statement Instructions and the NAIC SAP include certain amounts that are based on the Company's estimates and judgments. These estimates require the Company to apply complex assumptions and judgments, often because the Company must make estimates about the effects of matters that are inherently uncertain and will change in subsequent periods. The most significant estimates relate to hospital and medical benefits, claims unpaid, aggregate health policy reserves (including medical loss ratio ("MLR") rebates and premium deficiency reserves ("PDR")), aggregate health claim reserves, risk corridor, and risk adjustment estimates. The Company adjusts these estimates each period as more current information becomes available. The impact of any changes in estimates is included in the determination of net income in the period in which the estimate is adjusted.

C. Accounting Policy

Basis of Presentation — The Company prepares its financial statements on the basis of accounting practices prescribed or permitted by the Department. These statutory practices differ from accounting principles generally accepted in the United States of America ("GAAP").

The Company has deemed the following to be significant differences between statutory practices and GAAP:

- Certain debt investments categorized as available-for-sale or held-to-maturity under GAAP are presented at the lower of book/adjusted carrying value or fair value in accordance with the NAIC designations in the financial statements, whereas under GAAP, these investments are shown at fair value or book/adjusted carrying value, respectively.
- Cash, cash equivalents, and short-term investments in the financial statements represent cash balances and investments with original maturities of one year or less from the time of acquisition, whereas under GAAP, the corresponding caption of cash, cash equivalents, and short-term investments includes cash balances and investments that will mature in one year or less from the balance sheet date. The Company reported $0 short-term investments as of December 31, 2022 and 2021, respectively.
- The statutory basis statements of cash flows reconcile the corresponding captions of cash, cash equivalents, and short-term investments, which can include restricted cash reserves, with original maturities of one year or less from the time of acquisition, whereas under GAAP, the statements of cash flows reconcile the corresponding captions of cash, cash equivalents and restricted cash with maturities of three months or less. Short-term investments with a final maturity of one year or less from the balance sheet date are not included in the reconciliation of GAAP cash flows. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and NAIC SAP. The statutory basis statements of cash flows are prepared in accordance with the NAIC Annual Statement Instructions.
- The NAIC SAP provides for an amount to be recorded for deferred taxes on temporary differences between the financial reporting and tax basis of assets, subject to a valuation allowance and admissibility limitations on deferred tax assets (see Note 9). In addition, under the NAIC SAP, the change in deferred tax assets is recorded directly to unassigned surplus in the financial statements, whereas under GAAP, the change in deferred tax assets is recorded as a component of the income tax provision within the income statement and is based on the ultimate recoverability of the deferred tax assets. Based on the admissibility criteria under the NAIC SAP, any deferred tax assets determined to be nonadmitted are charged directly to surplus and excluded from the financial statements, whereas under GAAP, such assets are included in the balance sheet.
- Reserves ceded to reinsurers for claims unpaid and aggregate health claim reserves have been reported as reductions of the related reserves rather than as assets, which would be required under GAAP.
- Certain assets, including certain aged premium receivables, certain health care receivable, prepaid expenses, and certain amounts receivable relating to uninsured plans, are considered nonadmitted assets under the NAIC SAP and are excluded from the financial statements and charged directly to unassigned surplus.
- Comprehensive income and its components are not separately presented in the financial statements, whereas under GAAP, it is a requirement to present comprehensive income and its components in the financial statements.

Accounting policy disclosures that are required by the NAIC Annual Statement instructions are as follows:

(1–2) Bonds are stated at book/adjusted carrying value if they meet NAIC designation of one or two and stated at the lower of book/adjusted carrying value or fair value if they meet an NAIC designation of three or higher. The Company does not have any mandatory convertible securities or Investment Analysis Office of the NAIC (“IAO”) identified funds

(i.e.: exchange traded funds or bond mutual funds) in its bond portfolio. Amortization of bond premium or accretion of discount is calculated using the constant yield interest method. Bonds are valued and reported using market prices published by the IAO in accordance with the NAIC Valuation of Securities manual prepared by the IAO or an external pricing service;

(3–4) The Company holds no common or preferred stock;

(5) The Company holds no mortgage loans on real estate;

(6) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the book/adjusted carrying value, commonly referred to as amortized cost, of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors. The Company's investment policy limits investments in nonagency residential mortgage-backed securities, including home equity and sub-prime mortgages, to 10% of total cash and invested assets. Total combined investments in mortgage-backed securities and asset-backed securities cannot exceed more than 30% of total cash and invested assets;

(7) The Company holds no investments in subsidiaries, controlled, or affiliated entities;

(8) The Company has no investment interests with respect to joint ventures, partnerships, or limited liability companies;

(9) The Company holds no derivatives;

(10) PDR (inclusive of conversion reserves) and the related expenses are recognized when it is probable that expected future health care expenses, claims adjustment expenses ("CAE"), direct administration costs, and an allocation of indirect administration costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries considered over the remaining lives of the contracts, and are recorded as aggregate health policy reserves in the financial statements. Indirect administration costs arise from activities that are not specifically identifiable to a specific group of existing contracts, and therefore, those costs are fully allocated among the various contract groupings. The allocation of indirect administration costs to each contract grouping is made proportionately to the expected margins remaining in the premiums after future health care expenses, CAE and direct administration costs are considered. The data and assumptions underlying such estimates and the resulting reserves are periodically updated, and any adjustments are reflected as an increase in reserves for accident, and health contracts in the financial statements in the period in which the change in estimate is identified. The Company does anticipate investment income as a factor in the PDR calculation (see Note 30);

(11) CAE are those costs expected to be incurred in connection with the adjustment and recording of accident and health claims. Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to its affiliate, UHS, in exchange for administrative and management services. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and general administrative expenses ("GAE") to be reported in the financial statements. It is the responsibility of UHS to pay CAE in the event the Company ceases operations. The Company has recorded an estimate of unpaid CAE associated with incurred but unpaid claims, which is included in unpaid CAE in the financial statements. Management believes the amount of the liability for unpaid CAE as of December 31, 2022 is adequate to cover the Company's cost for the adjustment and recording of unpaid claims; however, actual expenses may differ from those established estimates. Adjustments to the estimates for unpaid CAE are reflected in operating results in the period in which the change in estimate is identified;

(12) The Company does not carry any fixed assets in the financial statements;

(13) Health care receivables consist of pharmacy rebates receivable estimated based on the most currently available data from the Company's claims processing systems and from data provided by the Company's affiliated pharmaceutical benefit manager, OptumRx, Inc. ("OptumRx"). Health care receivables also include receivables for amounts due to the Company for claim and capitation overpayments to providers, hospitals and other health care organizations. Health care receivables are considered nonadmitted assets under the NAIC SAP if they do not meet admissibility requirements. Accordingly, the Company has excluded receivables that do not meet the admissibility criteria from the financial statements (see Note 28).

The Company has also deemed the following to be significant accounting policies:

ASSETS

Cash and Invested Assets

- Bonds include securities with a maturity of greater than one year at the time of purchase;
- Cash equivalents include securities that have original maturity dates of three months or less from the date of acquisition. Cash equivalents, excluding money-market funds, are reported at cost or book/adjusted carrying value depending on the nature of the underlying security, which approximates fair value. Money-market funds are reported at fair value or net asset value ("NAV") as a practical expedient;
- Realized capital gains and losses on sales of investments are calculated based upon specific identification of the investments sold. These gains and losses are reported as net realized capital gains less capital gains tax ("net realized capital gains (losses) less taxes") in the financial statements;
- The Company continually monitors the difference between amortized cost and estimated fair value of its investments. If any of the Company's investments experience a decline in value that the Company has determined is other-than-temporary, or if the Company has determined it will sell a security that is in an impaired status, the Company will record a realized loss in net realized capital gains (losses) less taxes in the financial statements. The new cost basis is not changed for subsequent recoveries in fair value. The prospective adjustment method is utilized for loan-backed securities for periods subsequent to the loss recognition (see Note 5).

Other Assets

- **Premiums and Considerations** — The Company reports uncollected premium balances from its insured members, CMS, and state Medicaid agencies as premiums and considerations in the financial statements. Uncollected premium balances that are over 90 days past due, with the exception of amounts due from government insured plans, are considered nonadmitted assets. In addition to those balances, current balances are also considered nonadmitted if the corresponding balance greater than 90 days past due is deemed more than inconsequential. Premiums and considerations also include amounts for CMS risk corridor receivables, CMS risk adjustment receivables for the Medicare Plan, KDHE pay for performance receivables, and HealthNet pay for performance receivables.

  Premium adjustments for the CMS risk corridor program are accounted for as premium adjustments subject to retrospectively rated features (see Note 24). Premium adjustments for the CMS risk adjustment and pay for performance programs are accounted for as premium adjustments subject to redetermination (see Note 24).

- **Amounts Receivable Relating to Uninsured Plans** — The Company reports amounts due to the Company from CMS and KDHE for the administrative activities it performs for which it has no insurance risk as amounts receivable relating to uninsured plans (see Note 18). Amounts receivable relating to uninsured plans include costs incurred by the Company that are in excess of the cost reimbursement under the Medicare Plan for the catastrophic reinsurance subsidy and the low-income member cost sharing subsidy, amounts due from the pharmaceutical manufacturers for reimbursement of the discounts under the Patient Protection and Affordable Care Act and its related legislation ("ACA") which mandates consumer discounts on brand name prescription drugs for Part D plan participants in the coverage gap, and amounts due from KDHE related to the high dollar rare disease drug reimbursement program.

LIABILITIES

- **Claims Unpaid and Aggregate Health Claim Reserves** — Claims unpaid and aggregate health claim reserves include claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees have received but for which claims have not yet been submitted, and payments and liabilities for physician, hospital, and other medical costs disputes.

  The estimates for incurred but not yet reported claims are developed using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as historical submission and payment data, cost trends, customer and product mix, seasonality, utilization of health care services, contracted service rates, and other relevant factors. The Company estimates such liabilities for physician, hospital, and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. These estimates may change as actuarial methods change or as underlying facts upon which estimates are based change. The Company did not change actuarial methods during 2022 and 2021. Management believes the amount of claims unpaid and aggregate health claim reserves is a best estimate of the Company's liability for unpaid claims and aggregate health claim reserves as of December 31, 2022; however, actual payments may differ from those established estimates.

  The Company contracts with hospitals, physicians, and other providers of health care under capitated or discounted fee for service arrangements, including a hospital per diem to provide medical care services to enrollees. Some of these contracts are with related parties (see Note 10). Capitated providers are at risk for the cost of medical care services provided to the Company's enrollees; however, the Company is ultimately responsible for the provision of services to its enrollees should the capitated provider be unable to provide the contracted services.

- **Aggregate Health Policy Reserves** — Aggregate health policy reserves includes CMS risk adjustment payables for the Medicare Plan, estimated MLR rebates payable for the Medicare Plan and HealthNet contract, KDHE pay for performance payables, estimated risk corridor payables due to HealthNet and KDHE, and the estimated amount for PDR.

  Premium adjustments for the estimated MLR rebates, and the HealthNet and KDHE risk corridor programs, are accounted for as premium adjustments subject to retrospectively rated features (see Note 24). Premium adjustments for the CMS risk adjustment and pay for performance programs are accounted for as premium adjustments subject to redetermination (see Note 24). PDR is specifically outlined in Note 30.

CAPITAL AND SURPLUS AND MINIMUM STATUTORY REQUIREMENTS

- **Restricted Cash Reserves** — The Company is in compliance with the various states regulatory deposit requirements as of December 31, 2022 and 2021, respectively, for qualification purposes as a domestic and foreign insurer. These restricted cash reserves are stated at book/adjusted carrying value, which approximates fair value. These restricted deposits are included in bonds in the financial statements. Interest earned on these deposits accrues to the Company (see Note 5).

- **Minimum Capital and Surplus** — Under the laws of the State of Missouri, the Company's domiciliary state, the Department requires the Company to maintain a minimum capital and surplus equal to 2% of the prior year net income, or $40,915,545 and $31,504,100 as of December 31, 2022 and 2021, respectively.

  RBC is a regulatory tool for measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. The Department requires the Company to maintain minimum capital and surplus equal to the greater of the state statute as outlined above, or the company action level as calculated by the RBC formula, or the level needed to avoid action pursuant to the trend test in the RBC formula.

  The Company is also subject to minimum capital and surplus requirements in other states where it is licensed to do business.

  The Company is in compliance with the minimum required capital and surplus amounts where it is licensed to do business, as of December 31, 2022 and 2021.

STATEMENTS OF OPERATIONS

- **Net Premium Income and Change in Reserve for Rate Credits** — Revenues consist of net premium income that is recognized in the period in which enrollees are entitled to receive health care services. Net premium income is shown net of reinsurance premiums paid and reinsurance premiums incurred but not paid in the financial statements.

  Comprehensive commercial health plans with MLRs on fully insured products, as calculated under the definitions in the ACA and implementing regulations, that fall below certain targets are required to rebate ratable portions of premiums annually. The Company classifies changes to the estimated rebates and retrospective premium adjustments as change in reserve for rate credits in the financial statements (see Note 24).

  Medicare Plans with MLRs on fully insured products, as calculated under the definitions in the ACA and implementing regulations, that fall below certain targets are required to rebate ratable portions of premiums annually. In addition, the Company records premium adjustments for changes to the CMS Medicare Plans risk corridor program. Changes to these estimates are reflected in change in reserve for rate credits in the financial statements (see Note 24). Net premium income also includes premium under the Medicare Plans which includes CMS premiums, including amounts pursuant to the CMS risk adjustment program (see Note 24), member premiums, and the CMS low-income premium subsidy for the Company's insurance risk coverage.

  The Medicaid plans are subject to experience rated rebates, including MLRs and risk corridor programs, and performance guarantees based on various utilization measures. The Company records premium adjustments for the changes to the estimates for experience rated rebates and risk corridor programs which are reflected in change in reserve for rate credits and for the performance guarantees which are reflected in net premium income in the financial statements (see Note 24). Net premium income also

includes amounts paid by state and federal governments on a per member basis in exchange for the provision and administration of medical benefits under the Medicaid and CHIP programs, and maternity payments. Premiums are contractual and are recognized in the coverage period in which members are entitled to receive services, except in the case of maternity payments. Maternity income is billed on contractual rates and recognized as income as each birth case is identified by the Company.

- **Total Hospital and Medical Expenses** — Total hospital and medical expenses include claims paid, claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees have received but for which claims have not yet been submitted, and payments and liabilities for physician, hospital, and other medical costs disputes.

  Total hospital and medical expenses also include amounts incurred for incentive pool, withhold adjustments, and bonus amounts that are based on the underlying contractual provisions with the respective providers. In addition, adjustments to claims unpaid estimates and aggregate health claim reserves are reflected in the period once the change in estimate is identified and included in total hospital and medical expenses in the financial statements.

- **General Administrative Expenses** — General expenses that have been paid as of the reporting date in addition to general expenses that have been incurred but are not due until a subsequent period are reported as general administrative expenses**.** Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to UHS in exchange for administrative and management services. Costs for items not included within the scope of the Agreement are directly expensed as incurred. State income taxes and premium taxes are also a component of GAE. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and GAE to be reported in the financial statements.

- **Federal Income Taxes Incurred** — The provision for federal income taxes incurred is calculated based on applying the statutory federal income tax rate of 21% to net income before federal income taxes and net realized capital gains subject to certain adjustments (see Note 9).

REINSURANCE

- **Reinsurance Ceded** — The Company has an insolvency-only reinsurance agreement with UnitedHealthcare Insurance Company ("UHIC"), an affiliate whereby 0.1% of net premium income is ceded to UHIC (see Note 23).

  The Company also has a reinsurance agreement through which 60% of comprehensive commercial and Medicaid earned member premiums, hospital and medical benefits**,** and operating expenses are ceded to UHIC (see Note 23).

- **Amounts Recoverable from Reinsurers** — The Company records amounts recoverable from reinsurers which represents amounts contractually due to the Company as net reinsurance recoveries in the financial statements.

- **Ceded Reinsurance Premiums Payable** — The ceded reinsurance premiums payable balance represents amounts due to the reinsurer for specified coverage which will be paid based on the contract terms.

OTHER

- **Vulnerability Due to Certain Concentrations** — The Company is subject to substantial federal and state government regulation, including licensing and other requirements

relating to the offering of the Company's existing products in new markets and offerings of new products, both of which may restrict the Company's ability to expand its business.

The Company has no commercial customers that individually exceed 10% of total direct premiums written and premiums and considerations, including receivables for contracts subject to redetermination, for the years ended December 31, 2022 and 2021.

Direct premiums written and premiums and considerations, including receivables for contracts subject to redetermination, from CMS related to the Medicare Plan as a percentage of total direct premiums written and total premiums and considerations, including receivables for contracts subject to redetermination, are 28% and 16% as of December 31, 2022 and 34% and 17% as of December 31, 2021, respectively.

Direct premiums written and premiums and consideration, including receivables for contracts subject to redetermination, from the KDHE as a percentage of total direct premiums written and total premiums and considerations, including receivables for contracts subject to redetermination, are 40% and 36% as of December 31, 2022 and 44% and 50% as of December 31, 2021, respectively. Direct premiums written and premiums and consideration, including receivables for contracts subject to redetermination, from HealthNet as a percentage of total direct premiums written and total premiums and consideration, including receivables for contracts subject to redetermination, are 32% and 48% as of December 31, 2022 and 22% and 33% as of December 31, 2021, respectively.

Recently Issued Accounting Standards — The Company reviewed all recently issued guidance in 2022 and 2021 that has been adopted for 2022 or subsequent years' implementation and has determined that none of the items would have a significant impact to the financial statements.

D. Going Concern

The Company has the ability and will continue to operate for a period of time sufficient to carry out its commitments, obligations and business objectives.

2. ACCOUNTING CHANGES AND CORRECTIONS OF ERRORS

No changes in accounting principles or corrections of errors have been recorded during the years ended December 31, 2022 and 2021.

3. BUSINESS COMBINATIONS AND GOODWILL

A–E. The Company was not party to a business combination during the years ended December 31, 2022 and 2021, and does not carry goodwill in its financial statements.

4. DISCONTINUED OPERATIONS

A. Discontinued Operation Disposed of or Classified as Held for Sale

(1–4) The Company did not have any discontinued operations disposed of or classified as held for sale during 2022 and 2021.

B. Change in Plan of Sale of Discontinued Operation — Not applicable.

C. Nature of any Significant Continuing Involvement with Discontinued Operations after Disposal — Not applicable.

D. Equity Interest Retained in the Discontinued Operation after Disposal — Not applicable.

5. INVESTMENTS

For purposes of calculating gross realized gains and losses on sales of investments, the amortized cost of each investment sold is used. There were no gross realized gains and losses on sales of long-term investments in 2022. The gross realized gains and losses on sales of long-term investments were $176,623 and $0, respectively, for 2021. There were no gross realized gains and losses on sales of short-term investments in 2022 and 2021. The net realized gain is included in net realized capital gains (losses) less taxes. Total proceeds on the sale of long-term investments were $0 and $2,413,444 in 2022 and 2021, respectively. There were no proceeds on sale of short-term investments in 2022 and 2021.

As of December 31, 2022 and 2021, the book/adjusted carrying value, fair value, and gross unrecognized unrealized gains and losses of the Company's investments, excluding cash and cash equivalents of $56,348,239 and $58,053,386 respectively, are disclosed in the table below:

	2022				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 12,963,568	$ -	$ 762,312	$ 513,464	$ 11,687,792
State and agency municipal securities	4,796,562	3,229	56,123	-	4,743,668
City and county municipal securities	8,540,083	11,446	77,346	218,982	8,255,201
Corporate debt securities	24,500,016	-	900,702	1,230,992	22,368,322
Total bonds	$ 50,800,229	$ 14,675	$ 1,796,483	$ 1,963,438	$ 47,054,983

	2022				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
Less than one year	$ 3,980,803	$ -	$ 28,234	$ 19,259	$ 3,933,310
One to five years	13,884,961	381	386,537	262,129	13,236,676
Five to ten years	20,079,278	14,294	657,392	1,041,020	18,395,160
Over ten years	12,855,187	-	724,320	641,030	11,489,837
Total bonds	$ 50,800,229	$ 14,675	$ 1,796,483	$ 1,963,438	$ 47,054,983

	2021				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 11,246,587	$ 224,616	$ 49,240	$ 7,658	$ 11,414,305
State and agency municipal securities	5,068,408	334,827	-	-	5,403,235
City and county municipal securities	8,756,204	488,489	18,121	-	9,226,572
Corporate debt securities	26,134,879	764,567	167,133	39,333	26,692,980
Total bonds	$ 51,206,078	$ 1,812,499	$ 234,494	$ 46,991	$ 52,737,092

Included in U.S. government and agency securities and corporate debt securities in the tables above are mortgage-related loan-backed securities, which do not have a single maturity date. For the years to maturity table above, these securities have been presented in the maturity group based on the securities' final maturity date and at a book/adjusted carrying value of $12,991,099 and fair value of $11,658,880.

The following table illustrates the fair value and gross unrecognized unrealized losses, aggregated by investment category and length of time that the individual securities have been in a continuous unrecognized unrealized loss position as of December 31, 2022 and 2021:

	2022					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 8,804,616	$ 762,312	$ 2,883,176	$ 513,464	$ 11,687,792	$ 1,275,776
State and agency municipal securities	3,335,279	56,123	-	-	3,335,279	56,123
City and county municipal securities	4,817,512	77,346	779,530	218,982	5,597,042	296,328
Corporate debt securities	15,437,347	900,702	6,930,975	1,230,992	22,368,322	2,131,694
Total bonds	$ 32,394,755	$ 1,796,483	$ 10,593,681	$ 1,963,438	$ 42,988,436	$ 3,759,921

	2021					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 3,464,096	$ 49,240	$ 365,116	$ 7,658	$ 3,829,212	$ 56,898
City and county municipal securities	980,235	18,121	-	-	980,235	18,121
Corporate debt securities	7,783,264	167,133	628,758	39,333	8,412,022	206,466
Total bonds	$ 12,227,595	$ 234,494	$ 993,874	$ 46,991	$ 13,221,469	$ 281,485

The unrecognized unrealized losses on investments in U.S. government and agency securities, state and agency municipal securities, city and county municipal securities, and corporate debt securities at December 31, 2022 and 2021, were mainly caused by interest rate fluctuations and not by unfavorable changes in the credit ratings associated with these securities. The Company evaluates impairment at each reporting period for each of the securities whereby the fair value of the investment is less than its book/adjusted carrying value. The contractual cash flows of the U.S. government and agency securities are guaranteed either by the U.S. government or an agency of the U.S. government. It is expected that the securities would not be settled at a price less than the cost of the investment, and the Company does not intend to sell the investment until the unrealized loss is fully recovered. The Company assessed the credit quality of the state and agency municipal securities, city and county municipal securities, and corporate debt securities, noting whether a significant deterioration since purchase or other factors that may indicate an other-than-temporary impairment ("OTTI"), such as the length of time and extent to which fair value has been less than cost, the financial condition, and near term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the investment. Additionally, the Company evaluated its intent and ability to retain loan-backed securities for a period of time sufficient to recover the amortized cost. As a result of these reviews, no OTTIs were recorded by the company as of December 31, 2022 and 2021.

A–C. The Company has no mortgage loans, real estate loans, restructured debt, or reverse mortgages. The Company also has no real estate property occupied by the Company, real estate property held for the production of income, or real estate property held for sale.

D. Loan-Backed Securities

(1) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the book/adjusted carrying value, commonly referred to as amortized cost, of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors.

(2) The Company did not recognize any OTTIs on loan-backed securities as of December 31, 2022.

(3) The Company did not have any loan-backed securities with OTTIs to report by CUSIP as of December 31, 2022 or 2021.

(4) The following table illustrates the fair value, gross unrecognized unrealized losses, and length of time that the loan-backed securities have been in a continuous unrecognized unrealized loss position as of December 31, 2022 and 2021:

	2022
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 701,105
2. 12 months or longer	631,113
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	7,991,279
2. 12 months or longer	3,667,601

	2021
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 66,024
2. 12 months or longer	7,658
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	4,734,727
2. 12 months or longer	365,116

(5) The Company believes that it will continue to collect timely the principal and interest due on its loan-backed securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate changes and not by unfavorable changes in the credit quality associated with these securities that impacted the assessment on collectability of principal and interest. At each reporting period, the Company evaluates available-for-sale debt securities for any credit-related impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the expected cash flows and the underlying credit quality and credit ratings of the issuers, noting no significant credit deterioration since purchase. As of December 31, 2022, the unrealized loss on any security that the Company classified as intent to sell was not material to the Company's investment portfolio. Any other securities in an unrealized loss position as of December 31, 2022, the Company considers to be temporary.

E. **Dollar Repurchase Agreements and/or Securities Lending Transactions** — Not applicable.

F. **Repurchase Agreements Transactions Accounted for as Secured Borrowing** — Not applicable.

G. **Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing** — Not applicable.

H. **Repurchase Agreements Transactions Accounted for as a Sale** — Not applicable.

I. Reverse Repurchase Agreements Transactions Accounted for as a Sale — Not applicable.

J. Real Estate — Not applicable.

K. Low-Income Housing Tax Credits — Not applicable.

L. Restricted Assets —

(1) Restricted assets, including pledged securities as of December 31, 2022 and 2021, are presented below:

Restricted Asset Category	1 Total Gross (Admitted & Nonadmitted) Restricted from Current Year	2 Total Gross (Admitted & Nonadmitted) Restricted from Prior Year	3 Increase/ (Decrease) (1 Minus 2)	4 Total Current Year Nonadmitted Restricted	5 Total Current Year Admitted Restricted (1 minus 4)	6 Gross (Admitted & Nonadmitted) Restricted to Total Assets (a)	7 Admitted Restricted to Total Admitted Assets (b)
a. Subject to contractual obligation for which liability is not shown	$ -	$ -	$ -	$ -	$ -	- %	- %
b. Collateral held under security lending agreements	-	-	-	-	-	-	-
c. Subject to repurchase agreements	-	-	-	-	-	-	-
d. Subject to reverse repurchase agreements	-	-	-	-	-	-	-
e. Subject to dollar repurchase agreements	-	-	-	-	-	-	-
f. Subject to dollar reverse repurchase agreements	-	-	-	-	-	-	-
g. Placed under option contracts	-	-	-	-	-	-	-
h. Letter stock or securities restricted as to sale — excluding FHLB capital stock	-	-	-	-	-	-	-
i. FHLB capital stock	-	-	-	-	-	-	-
j. On deposit with states	931,081	932,749	(1,668)	-	931,081	<1	<1
k. On deposit with other regulatory bodies	-	-	-	-	-	-	-
l. Pledged as collateral to FHLB (including assets backing funding agreements)	-	-	-	-	-	-	-
m. Pledged as collateral not captured in other categories	-	-	-	-	-	-	-
n. Other restricted assets	-	-	-	-	-	-	-
o. Total restricted assets	$ 931,081	$ 932,749	$ (1,668)	$ -	$ 931,081	<1%	<1%

(a) Column 1 divided by Asset Page, Column 1, Line 28
(b) Column 5 divided by Asset Page, Column 3, Line 28

(2–4) The Company has no assets pledged as collateral not captured in other categories and no other restricted assets as of December 31, 2022 or 2021.

M. Working Capital Finance Investments — Not applicable.

N. Offsetting and Netting of Assets and Liabilities

The Company does not have any offsetting or netting of assets and liabilities as it relates to derivatives, repurchase and reverse repurchase agreements, and securities borrowing and securities lending activities.

O. 5GI Securities

The Company does not have any investments with an NAIC designation of 5GI as of December 31, 2022 and 2021.

P. Short Sales — Not applicable.

Q. Prepayment Penalty and Acceleration Fees

The following table illustrates prepayment penalty and acceleration fees as of December 31, 2022:

	General Account
1. Number of CUSIPs	2
2. Aggregate amount of investment income	$ 3,119

R. Reporting Entity's Share of Cash Pool by Asset Type — Not applicable.

6. JOINT VENTURES, PARTNERSHIPS, AND LIMITED LIABILITY COMPANIES

A–B. The Company has no investments in joint ventures, partnerships, or limited liability companies that exceed 10% of admitted assets and did not recognize any impairment write-down for its investments in joint ventures, partnerships, and limited liability companies during the statement periods.

7. INVESTMENT INCOME

A. The Company excludes all investment income due and accrued amounts that are over 90 days past due from the financial statements.

B. There were no investment income amounts excluded from the financial statements.

8. DERIVATIVE INSTRUMENTS

A–B. The Company has no derivative instruments.

9. INCOME TAXES

The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group. The Company does not expect to be liable for the Corporate Alternative Minimum Tax in 2023.

A. Deferred Tax Asset/Liability

(1) The components of the net deferred tax asset at December 31, 2022 and 2021 are as follows:

	2022			2021			Change		
	1 Ordinary	2 Capital	3 (Col 1+2) Total	4 Ordinary	5 Capital	6 (Col 4+5) Total	7 (Col 1 - 4) Ordinary	8 (Col 2 - 5) Capital	9 (Col 7+8) Total
(a) Gross deferred tax assets	$ 2,930,514	$ -	$ 2,930,514	$ 1,744,795	$ -	$ 1,744,795	$ 1,185,719	$ -	$ 1,185,719
(b) Statutory valuation allow ance adjustments	-	-	-	-	-	-	-	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	2,930,514	-	2,930,514	1,744,795	-	1,744,795	1,185,719	-	1,185,719
(d) Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	2,930,514	-	2,930,514	1,744,795	-	1,744,795	1,185,719	-	1,185,719
(f) Deferred tax liabilities	35,267	-	35,267	47,023	-	47,023	(11,756)	-	(11,756)
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	$ 2,895,247	$ -	$ 2,895,247	$ 1,697,772	$ -	$ 1,697,772	$ 1,197,475	$ -	$ 1,197,475

(2) The components of the adjusted gross deferred tax assets admissibility calculation under SSAP No. 101, *Income Taxes,* are as follows:

	2022			2021			Change		
Admission Calculation Components SSAP No. 101	1 Ordinary	2 Capital	3 (Col 1 + 2) Total	4 Ordinary	5 Capital	6 (Col 4 + 5) Total	7 (Col 1 - 4) Ordinary	8 (Col 2 - 5) Capital	9 (Col 7 + 8) Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 2,930,514	$ -	$ 2,930,514	$ 1,744,795	$ -	$ 1,744,795	$ 1,185,719	$ -	$ 1,185,719
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation. (The lesser of 2(b)1 and 2(b)2 below)	-	-	-	-	-	-	-	-	-
1. Adjusted gross deferred tax assets expected to be realized follow ing the balance sheet date	-	-	-	-	-	-	-	-	-
2. Adjusted gross deferred tax assets allow ed per limitation threshold	XXX	XXX	47,277,793	XXX	XXX	45,206,203	XXX	XXX	2,071,590
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	-	-	-	-	-	-	-	-	-
(d) Deferred tax assets admitted as the result of application of SSAP No. 101 Total (2(a) + 2(b) + 2(c))	$ 2,930,514	$ -	$ 2,930,514	$ 1,744,795	$ -	$ 1,744,795	$ 1,185,719	$ -	$ 1,185,719

(3) The ratio percentage and adjusted capital and surplus used to determine the recovery period and threshold limitations for the admissibility calculation are presented below:

	2022	2021
(a) Ratio percentage used to determine recovery period and threshold limitation amount	>300%	>300%
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)(2) above	$ 315,185,284	$ 301,374,685

(4) The impact to the gross deferred tax assets balances as a result of tax-planning strategies as of December 31, 2022 and 2021 is presented below:

	2022		2021		Change	
	1	2	3	4	5	6
Impact of Tax-Planning Strategies	Ordinary	Capital	Ordinary	Capital	(Col 1 - 3) Ordinary	(Col 2 - 4) Capital
(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets by tax character as a percentage.						
1. Adjusted gross DTAs amount from Note 9A1(c)	$ 2,930,514	$ -	$ 1,744,795	$ -	$ 1,185,719	$ -
2. Percentage of adjusted gross DTAs by tax character attributable to the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
3. Net admitted adjusted gross DTAs amount from Note 9A1(e)	$ 2,930,514	$ -	$ 1,744,795	$ -	$ 1,185,719	$ -
4. Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
(b) Does the Company's tax-planning strategies include the use of reinsurance?			Yes		No X	

B. Unrecognized Deferred Tax Liabilities

(1–4) There are no unrecognized deferred tax liabilities for the years ended December 31, 2022 and 2021.

C. Significant Components of Income Taxes

(1) The current federal income taxes incurred for the years ended December 31, 2022 and 2021 are as follows:

	1	2	3
	2022	2021	(Col 1 - 2) Change
1. Current income tax			
(a) Federal	$ 41,052,105	$ 34,874,994	$ 6,177,111
(b) Foreign	-	-	-
(c) Subtotal (1a + 1b)	41,052,105	34,874,994	6,177,111
(d) Federal income tax on net capital gains	91	37,111	(37,020)
(e) Utilization of capital loss carryforwards	-	-	-
(f) Other	-	-	-
(g) Federal and foreign income taxes incurred (1c + 1d + 1e + 1f)	$ 41,052,196	$ 34,912,105	$ 6,140,091

(2–4) The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities as of December 31, 2022 and 2021, are as follows:

	1 2022	2 2021	3 (Col 1 - 2) Change
2 Deferred tax assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$ 401,242	$ 269,508	$ 131,734
(2) Unearned premium reserve	4	5	(1)
(3) Policyholder reserves	397	397	-
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	-	-	-
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables — nonadmitted	2,528,871	1,474,885	1,053,986
(11) Net operating loss carryforward	-	-	-
(12) Tax credit carryforward	-	-	-
(13) Other	-	-	-
(99) Subtotal (sum of 2a1 through 2a13)	2,930,514	1,744,795	1,185,719
(b) Statutory valuation allowance adjustment	-	-	-
(c) Nonadmitted	-	-	-
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	2,930,514	1,744,795	1,185,719
(e) Capital:			
(1) Investments	-	-	-
(2) Net capital loss carryforward	-	-	-
(3) Real estate	-	-	-
(4) Other	-	-	-
(99) Subtotal (2e1 + 2e2 + 2e3 + 2e4)	-	-	-
(f) Statutory valuation allowance adjustment	-	-	-
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	-	-	-
(i) Admitted deferred tax assets (2d + 2h)	2,930,514	1,744,795	1,185,719
3 Deferred tax liabilities:			
(a) Ordinary:			
(1) Investments	-	-	-
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other	35,267	47,023	(11,756)
(99) Subtotal (3a1 + 3a2 + 3a3 + 3a4 + 3a5)	35,267	47,023	(11,756)
(b) Capital:			
(1) Investments	-	-	-
(2) Real estate	-	-	-
(3) Other	-	-	-
(99) Subtotal (3b1 + 3b2 + 3b3)	-	-	-
(c) Deferred tax liabilities (3a99 + 3b99)	35,267	47,023	(11,756)
4 Net deferred tax assets/liabilities (2i - 3c)	$ 2,895,247	$ 1,697,772	$ 1,197,475

The Company assessed the potential realization of the gross deferred tax asset and as a result no statutory valuation allowance was required and no allowance was established as of December 31, 2022 and 2021.

D. The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate of 21% to net income before federal income taxes incurred, plus capital gains tax. A summarization of the significant items causing this difference as of December 31, 2022 and 2021 is as follows:

	2022		2021	
	Amount	Effective Tax Rate	Amount	Effective Tax Rate
Tax provision at the federal statutory rate	$ 40,925,174	21 %	$ 35,062,964	21 %
Tax-exempt interest	(49,997)	-	(51,454)	-
Other current year items	33,530	-	28,137	-
Tax effect of nonadmitted assets	(1,053,986)	(1)	(74,142)	-
Total statutory income taxes	$ 39,854,721	20 %	$ 34,965,505	21 %
Federal income taxes incurred	$ 41,052,105	21 %	$ 34,874,994	21 %
Capital gains tax	91	-	37,111	-
Change in net deferred income tax	(1,197,475)	(1)	53,400	-
Total statutory income taxes	$ 39,854,721	20 %	$ 34,965,505	21 %

E. At December 31, 2022, the Company had no net operating loss carryforwards.

Current federal income taxes payable of $1,282,195 and $2,287,104 as of December 31, 2022 and 2021, respectively, are included in the financial statements. Federal income taxes paid, net of refunds, were $42,057,105 and $31,030,741 in 2022 and 2021, respectively.

Federal income taxes incurred of $41,052,196 and $34,912,105 for 2022 and 2021, respectively, are available for recoupment in the event of future net losses.

The Company has not admitted any aggregate amounts of deposits that are included within Section 6603 (“Deposits made to suspend running of interest on potential underpayments, etc.”) of the Internal Revenue Service (“IRS”) Code.

F. The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group. The entities included within the consolidated return are included in the NAIC Statutory Statement Schedule Y - Information Concerning Activities of Insurer Members Of A Holding Company Group. Federal income taxes are paid to or refunded by UnitedHealth Group pursuant to the terms of a tax-sharing agreement, approved by the Board of Directors, under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal return of UnitedHealth Group. UnitedHealth Group currently files income tax returns in the U.S. federal jurisdiction, various states, and foreign jurisdictions. The U.S. IRS has completed exams on UnitedHealth Group’s consolidated income tax returns for fiscal years 2016 and prior. UnitedHealth Group’s 2017 through 2020 tax returns are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, UnitedHealth Group is no longer subject to income tax examinations prior to the 2014 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2015 and forward. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

G. **Tax Contingencies** — Not applicable.

H. **Repatriation Transition Tax** — Not applicable.

I. **Alternative Minimum Tax Credit** — Not applicable.

10. INFORMATION CONCERNING PARENT, SUBSIDIARIES, AND AFFILIATES

A–B. In the ordinary course of business, the Company contracts with several affiliates to provide a wide variety of services to the Company's members. These agreements are filed with and approved by the Department according to Management's understanding of the current requirements and standards. Within the confines of the applicable filed and approved agreements (including subsequent amendments thereto), the amount and types of services provided by these affiliated entities can change year over year.

The Company has a tax-sharing agreement with UnitedHealth Group (see Note 9).

The Company paid dividends of $135,000,000 and $85,000,000 in 2022 and 2021, respectively, to its parent (see Note 13).

The Company held a $40,000,000 subordinated revolving credit agreement with UnitedHealth Group at an interest rate of London InterBank Offered Rate plus a margin of 0.50%. This credit agreement was subordinate to the extent it did not conflict with any credit facility held by either party. The agreement was terminated effective December 31, 2022. No amounts were outstanding under the line of credit as of December 31, 2022 and 2021. No amount of interest was paid or still accrued on all borrowings throughout the years of December 31, 2022 and 2021, respectively.

The Company has entered into reinsurance agreements with an affiliated entity (see Note 23).

C. Transactions With Related Parties Who Are Not Reported On Schedule Y

The Company has no material related party transactions that meet the disclosure requirements pursuant to SSAP No. 25, *Affiliates and Other Related Parties* ("SSAP No. 25") that are not included in NAIC Statutory Statement Schedule Y — Part 2 Summary Of Insurer's Transactions With Any Affiliates.

D. At December 31, 2022 and 2021, the Company reported $8,557,309 and $16,647,481, respectively, as amounts due to parent, subsidiaries, and affiliates, which are included in the financial statements. These balances are generally settled within 90 days from the incurred date. Any balances due to the Company that are not settled within 90 days are considered nonadmitted assets.

E. The administrative services, access fees, and cost of care services provided by affiliates are calculated using one or more of the following methods: (1) a percentage of premiums; (2) use of assets; (3) direct pass-through of charges; (4) per member per month; (5) per employee per month; (6) per claim; or (7) a combination thereof consistent with the provisions contained in each contract. These amounts are included in GAE, CAE, and hospital and medical expenses in the financial statements. The following table identifies the amounts reported for the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2022 and 2021, which meet the disclosure requirements pursuant to SSAP No. 25, regardless of the effective date of the contract:

	2022	2021
Optum Health Networks, Inc.	$ 700,247,976	$ 707,068,219
OptumRx	235,137,207	237,853,921
UHS	219,200,203	200,440,695
United Behavioral Health	212,254,245	179,330,658
naviHealth, Inc.	10,251,020	6,596,222
Dental Benefit Providers, Inc.	6,427,009	4,774,360
OptumInsight, Inc.	5,911,619	6,046,049

Optum Health Network, Inc. provides services that may include, but are not limited to, care management services to eligible members and/or arranging for the delivery of clinical services to the Company's enrollees.

OptumRx provides services that may include, but are not limited to, administrative services related to pharmacy management and pharmacy claims processing for enrollees, manufacturer rebate administration, pharmacy incentive services, specialty drug pharmacy services, durable medical equipment services including orthotics and prosthetics and personal health products catalogues showing the healthcare products and benefit credits enrollees needed to redeem the respective products.

UHS provides, or arranges for the provision of, management, administrative, and other services deemed necessary or appropriate for UHS to provide management and operational support to the Company. The services can include, but are not limited to, the categories of management and operational services outlined in the Agreement, such as human resources, legal, facilities, general administration, treasury and investment functions, claims adjudication and payment, benefit administration, disease management, health care decision support, medical management, credentialing, preventative health services, utilization management reporting and expenses incurred for new business that will be effective in the subsequent year.

United Behavioral Health provides services related to mental health and substance abuse treatment.

naviHealth, Inc. provides comprehensive post-acute services and care delivery.

Dental Benefit Providers, Inc. provides dental care assistance.

OptumInsight, Inc. provides services that may include, but are not limited to, coordination of benefits and data mining, retrospective fraud and waste abuse, subrogation and audit services. All recoveries are returned to the Company by OptumInsight, Inc. on a monthly basis.

The Company has premium payments that are received and claim payments that are processed and paid by an affiliated UnitedHealth Group entity. Premiums, claims, and direct expenses applicable to the Company are settled at regular intervals throughout the month via the intercompany settlement process and any amounts outstanding are reflected in payables due to parent, subsidiaries, and affiliates in the financial statements.

F. The Company's affiliate, UHS, provides a guarantee to the KDHE to perform the Company's obligations and discharge its liabilities under the Medicaid contract should the Company fail to perform. The parent will also indemnify and hold harmless the KDHE against any and all losses, damages, claims, costs, charges, and expenses under the terms of the contract. The Company has not extended any guarantees or undertakings for the benefit of an affiliate or related party.

G. The Company is part of an insurance holding company system with UnitedHealth Group as the ultimate parent. Management believes that the Company's transactions with affiliates are fair and reasonable; however, operations of the Company may not be indicative of those that would have occurred if it had operated as an independent company.

H. The Company does not have any amount deducted from the value of an upstream intermediate entity or ultimate parent owned, either directly or indirectly, via a downstream subsidiary, controlled, or affiliated entity.

I. The Company does not have any investments in a subsidiary, controlled, or affiliated entity that exceeds 10% of admitted assets.

J. The Company does not have any investments in impaired subsidiaries, controlled, or affiliated entities.

K. The Company does not have any investments in foreign insurance subsidiaries.

L. The Company does not hold any investments in a downstream noninsurance holding company.

M. The Company does not have any investments in noninsurance subsidiaries, controlled, or affiliated entities.

N. The Company does not have any investments in insurance subsidiaries, controlled, or affiliated entities.

O. The Company does not have any investments in subsidiary, controlled, or affiliated entities or joint ventures, partnerships and limited liability companies in which the Company's share of losses exceeds the investment.

11. DEBT

A–B. The Company had no outstanding debt with third-parties or outstanding Federal Home Loan Bank agreements during 2022 and 2021.

12. RETIREMENT PLANS, DEFERRED COMPENSATION, POSTEMPLOYMENT BENEFITS AND COMPENSATED ABSENCES AND OTHER POSTRETIREMENT BENEFIT PLANS

A–I. The Company has no defined benefit plans, defined contribution plans, multiemployer plans, consolidated/holding company plans, postemployment benefits, or compensated absences plans and is not impacted by the Medicare Modernization Act on postretirement benefits, since all personnel are employees of UHS, which provides services to the Company under the terms of the Agreement (see Note 10).

13. CAPITAL AND SURPLUS, DIVIDEND RESTRICTIONS, AND QUASI-REORGANIZATIONS

A–B. The Company has 100 shares authorized and 1 share issued and outstanding of $1 par value common stock. The Company has no preferred stock outstanding. All issued and outstanding shares of common stock are held by the Company's parent, UHC.

C. Dividend payment requirements are outlined in the domiciliary state statutes and may be further restricted by the Department.

D. The Company paid extraordinary cash dividends to UHC of $85,000,000 and $50,000,000 on June 21, 2022 and December 7, 2022, which were approved by the Department and recorded as a reduction to unassigned surplus in the financial statements.

The Company paid extraordinary cash dividends of $50,000,000 and $35,000,000 on September 20, 2021 and December 17, 2021, respectively, to UHC which were approved by the Department and recorded as a reduction to unassigned surplus in the financial statements.

E. The amount of ordinary dividends that may be paid out during any given period is subject to certain restrictions as specified by state statute.

F. There are no restrictions placed on the Company's unassigned surplus.

G. The Company is not a mutual reciprocal or a similarly organized entity and does not have advances to surplus not repaid.

H. The Company does not hold any stock, including stock of affiliated companies for special purposes, such as conversion of preferred stock, employee stock options, or stock purchase warrants.

I. The Company does not have any special surplus funds.

J. The portion of unassigned surplus, excluding net income and dividends, represented (or reduced) by each item below is as follows:

	2022	2021
Net deferred income taxes	$ 2,895,247	$ 1,697,772
Nonadmitted assets	(12,042,243)	(7,023,261)
Total	$ (9,146,996)	$ (5,325,489)

K–M. The Company does not have any outstanding surplus notes and has never been a party to a quasi-reorganization.

14. LIABILITIES, CONTINGENCIES AND ASSESSMENTS

A. Contingent Commitments

The Company has no contingent commitments.

B. Assessments

The Company is not aware of any guaranty fund assessments or premium tax offsets, potential or accrued, that could have a material financial effect on the operations of the entity.

C. Gain Contingencies

The Company is not aware of any gain contingencies that should be disclosed in the financial statements.

D. Claims Related Extra Contractual Obligation and Bad Faith Losses Stemming from Lawsuits — Not applicable.

E. Joint and Several Liabilities — Not applicable.

F. All Other Contingencies

The Company's business is regulated at the federal, state, and local levels. The laws and rules governing the Company's business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Further, the Company must obtain and maintain regulatory approvals to market and sell many of its products.

The Company has been, or is currently involved, in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments and other governmental authorities. The Company cannot reasonably estimate the range of loss, if any, that may result from any material government investigations, audits and reviews in which it is currently involved given the inherent difficulty in predicting regulatory action, fines and penalties, if any, and the various remedies and levels of judicial review available to the Company in the event of an adverse finding.

On February 14, 2017, the Department of Justice ("DOJ") announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges that the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, the DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters involve: indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility, or it is probable that a loss may be incurred. Although the outcomes of any such legal actions cannot be predicted, in the opinion of management, the resolution of any currently pending or threatened actions will not have a material adverse effect on the financial statements of the Company.

The Company routinely evaluates the collectability of all receivable amounts included in the financial statements. Impairment reserves are established for those amounts where collectability is uncertain. Based on the Company's past experience, exposure related to uncollectible balances and the potential of loss for those balances not currently reserved for is not material to the Company's statutory basis financial condition.

There are no assets that the Company considers to be impaired at December 31, 2022 and 2021.

15. LEASES

A–B. According to the Agreement between the Company and UHS (see Note 10), operating leases for the rental of office facilities and equipment are the responsibility of UHS. Fees associated with the lease agreements are included as a component of the Company's management fee.

16. INFORMATION ABOUT FINANCIAL INSTRUMENTS WITH OFF-BALANCE-SHEET RISK AND FINANCIAL INSTRUMENTS WITH CONCENTRATIONS OF CREDIT RISK

(1–4) The Company does not hold any financial instruments with off-balance-sheet risk or have any concentrations of credit risk.

17. SALE, TRANSFER, AND SERVICING OF FINANCIAL ASSETS AND EXTINGUISHMENTS OF LIABILITIES

A–C. The Company did not participate in any transfer of receivables, financial assets or wash sales.

18. GAIN OR LOSS TO THE REPORTING ENTITY FROM UNINSURED PLANS AND THE UNINSURED PORTION OF PARTIALLY INSURED PLANS

A–B. The Company has no operations from Administrative Services Only Contracts or Administrative Services Contracts in 2022 and 2021.

C. Medicare or Other Similarly Structured Cost Based Reimbursement Contract

The Medicare Part D program is a partially insured plan. The Company recorded a receivable of $18,000,498 and $39,644,087 at December 31, 2022 and 2021, respectively, for cost reimbursement under the Medicare Part D program for the catastrophic reinsurance and low-income member cost-sharing subsidies. The Company also recorded a receivable of $28,466 and $28,299 at December 31, 2022 and 2021, respectively, for the Medicare Part D coverage gap discount program. The receivables are recorded in amounts receivable relating to uninsured plans in the financial statements. These Medicare subsidies are described in Note 1, *Amounts Receivable Relating to Uninsured Plans.*

Effective July 1, 2022, the Company participates in the KDHE high dollar rare disease drug reimbursement program. There is no risk to the Company as a result of these transactions. The Company has a related program receivable of $2,056,585 as of December 31, 2022, which is included in amounts receivable relating to uninsured plans in the financial statements.

The Company participated in administering the payments for the HealthNet's Federal Reimbursement Allowance ("FRA") program. There is no risk to the Company as a result of these transactions. The Company has an FRA program payable of $0 and $1,149,255 as of December 31, 2022 and 2021, respectively, which is included in liability for amounts held under uninsured plans in the financial statements.

19. DIRECT PREMIUM WRITTEN/PRODUCED BY MANAGING GENERAL AGENTS/THIRD-PARTY ADMINISTRATORS

The Company did not have any direct premiums written or produced by managing general agents or third-party administrators in 2022 and 2021.

20. FAIR VALUE MEASUREMENTS

The NAIC SAP defines fair value, establishes a framework for measuring fair value, and outlines the disclosure requirements related to fair value measurements. The fair value hierarchy is as follows:

Level 1 — Quoted (unadjusted) prices for identical assets in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets in active markets;
- Quoted prices for identical or similar assets in nonactive markets (few transactions, limited information, noncurrent prices, high variability over time, etc.);
- Inputs other than quoted prices that are observable for the asset (interest rates, yield curves, volatilities, default rates, etc.);
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

The estimated fair values of bonds and cash equivalents are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service ("pricing service"), which generally uses quoted prices or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, non-binding broker quotes, benchmark yields, credit spreads, default rates, and prepayment speeds. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to a secondary pricing source, prices reported by its custodian, its investment consultant, and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and review of fair value methodology documentation provided by independent pricing services have not historically resulted in an adjustment in the prices obtained from the pricing service.

In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement has been determined based on the lowest-level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

A. Fair Value

(1) Fair Value Measurements at Reporting Date

The following tables present information about the Company's financial assets that are measured and reported at fair value at December 31, 2022 and 2021, in the financial statements according to the valuation techniques the Company used to determine their fair values:

	December 31, 2022				
Description for Each Class of Asset or Liability	**(Level 1)**	**(Level 2)**	**(Level 3)**	**Net Asset Value (NAV)**	**Total**
a. Assets at fair value:					
Perpetual preferred stock:					
Industrial and misc	$ -	$ -	$ -	$ -	$ -
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total perpetual preferred stocks	-	-	-	-	-
Bonds:					
U.S. governments	-	-	-	-	-
Industrial and misc	-	-	-	-	-
Hybrid securities	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total bonds	-	-	-	-	-
Common stock:					
Industrial and misc	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stocks	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forward contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	51,304,359	-	-	-	51,304,359
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 51,304,359	$ -	$ -	$ -	$ 51,304,359
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

Description for Each Class of Asset or Liability	December 31, 2021 (Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Total
a. Assets at fair value:					
Perpetual preferred stock:					
Industrial and misc	$ -	$ -	$ -	$ -	$ -
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total perpetual preferred stocks	-	-	-	-	-
Bonds:					
U.S. governments	-	-	-	-	-
Industrial and misc	-	-	-	-	-
Hybrid securities	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total bonds	-	-	-	-	-
Common stock:					
Industrial and misc	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stocks	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forward contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	57,799,537	-	-	-	57,799,537
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 57,799,537	$ -	$ -	$ -	$ 57,799,537
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

(2) The Company does not have any financial assets with a fair value hierarchy of Level 3 that were measured and reported at fair value.

(3) Transfers between fair value hierarchy levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs. There were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during the years ended December 31, 2022 or 2021.

(4) The Company has no investments reported with a fair value hierarchy of Level 2 or Level 3 and therefore has no valuation technique to disclose.

(5) The Company has no derivative assets and liabilities to disclose.

B. Fair Value Combination — Not applicable.

C. Aggregate Fair Value Hierarchy

The aggregate fair value by hierarchy of all financial instruments as of December 31, 2022 and 2021 is presented in the table below:

	December 31, 2022						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 11,687,792	$ 12,963,568	$ 3,601,228	$ 8,086,564	$ -	$ -	$ -
State and agency municipal securities	4,743,668	4,796,562	-	4,743,668	-	-	-
City and county municipal securities	8,255,201	8,540,083	-	8,255,201	-	-	-
Corporate debt securities	22,368,322	24,500,016	-	22,368,322	-	-	-
Cash equivalents	56,296,904	56,296,904	56,296,904	-	-	-	-
Total bonds and cash equivalents	$ 103,351,887	$ 107,097,133	$ 59,898,132	$ 43,453,755	$ -	$ -	$ -

	December 31, 2021						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 11,414,305	$ 11,246,587	$ 3,060,572	$ 8,353,733	$ -	$ -	$ -
State and agency municipal securities	5,403,235	5,068,408	-	5,403,235	-	-	-
City and county municipal securities	9,226,572	8,756,204	-	9,226,572	-	-	-
Corporate debt securities	26,692,980	26,134,879	-	26,692,980	-	-	-
Cash equivalents	57,799,537	57,799,537	57,799,537	-	-	-	-
Total bonds and cash equivalents	$ 110,536,629	$ 109,005,615	$ 60,860,109	$ 49,676,520	$ -	$ -	$ -

D. Not Practicable to Estimate Fair Value — Not applicable.

E. Investments Measured Using the NAV Practical Expedient — Not applicable.

21. OTHER ITEMS

A. Unusual or Infrequent Items

The Company did not encounter any unusual or infrequent items for the years ended December 31, 2022 and 2021.

B. Troubled Debt Restructuring: Debtors

The Company has no troubled debt restructurings as of December 31, 2022 and 2021.

C. Other Disclosures

The Company does not have any amounts not recorded in the financial statements that represent segregated funds held for others. The Company also does not have any exposures related to forward commitments that are not derivative instruments.

D. Business Interruption Insurance Recoveries

The Company has not received any business interruption insurance recoveries during 2022 and 2021.

E. State Transferable and Non-transferable Tax Credits

The Company has no transferable or non-transferable state tax credits.

F. Sub-Prime Mortgage-Related Risk Exposure

(1) The investment policy for the Company limits investments in loan backed securities, which includes subprime issuers. Further, the policy limits investments in private issuer mortgage securities to 10% of the portfolio, which also includes subprime issuers. The exposure to unrealized losses on subprime issuers is due to changes in market prices. There are no realized losses due to not receiving anticipated cash flows. The investments covered have an NAIC designation of 1 or 2.

(2) The Company has no direct exposure through investments in sub-prime mortgage loans.

(3) The Company has no direct exposure through other investments.

(4) The Company has no underwriting exposure to sub-prime mortgage risk through mortgage guaranty or financial guaranty insurance coverage.

G. Retained Assets

The Company does not have any retained asset accounts for beneficiaries.

H. Insurance-Linked Securities Contracts

As of December 31, 2022, the Company is not aware of any possible proceeds of insurance-linked securities.

I. The Amount That Could Be Realized on Life Insurance Where the Reporting Entity is Owner and Beneficiary or Has Otherwise Obtained Rights to Control the Policy — Not applicable.

22. EVENTS SUBSEQUENT

Subsequent events have been evaluated through May 11, 2023, which is the date these financial statements were available for issuance.

TYPE I — Recognized Subsequent Events

Any material Type I events subsequent to December 31, 2022, have been recognized in the financial statements and corresponding disclosures.

TYPE II — Non-Recognized Subsequent Events

Effective January 1, 2023, the Company novated its Dual Special Needs Plan CMS contract to an affiliate, UnitedHealthcare of Wisconsin, Inc. The novation agreements resulted in full control of the contracts being transferred to UnitedHealthcare of Wisconsin, Inc. at $0 net book value for dates of service on or after January 1, 2023. Approval for this novation was received from CMS. The 2022 Medicare revenue subject to the novation represented approximately 28% of total direct premiums written.

There are no other material non-recognized Type II events that require disclosure.

23. REINSURANCE

Reinsurance Agreements — In the normal course of business, the Company seeks to reduce potential losses that may arise from catastrophic events that cause unfavorable underwriting results by reinsuring certain levels of such risk with an affiliated reinsurer. The Company remains primarily liable as the direct insurer on all risks reinsured.

The Company has a reinsurance agreement with UHIC, an affiliate of the Company, through which 60% of earned comprehensive commercial and Medicaid member premiums, hospital and medical expenses, and operating expenses are transferred to UHIC. The Company transferred premiums of $1,709,528,144 and $1,351,518,927, and GAE and CAE of $169,304,541 and $145,514,774 in 2022 and 2021, respectively, to UHIC under this agreement. The Company recorded receivables related to

changes in reserve estimates of $169,150,541 and $87,209,268 in 2022 and 2021, respectively, which are netted against claims unpaid and aggregate health claim reserves in the financial statements. The Company recorded reinsurance receivables of $46,830,349 and $10,188,947 in 2022 and 2021, respectively, related to HealthNet and KDHE risk corridor reserves, which are netted against aggregate health policy reserves in the financial statements. The Company recognized reinsurance recoveries of $1,387,801,902 and $1,087,369,469 in 2022 and 2021, respectively, which are recorded as net reinsurance recoveries in the financial statements. The Company recorded ceded reserves for provider incentives of $5,835,612 and $2,469,980 in 2022 and 2021, respectively, which are included in accrued medical incentive pool and bonus amounts in the financial statements. The Company recorded paid claims receivables related to this agreement, including payments made for the MLR rebates, of $132,443,356 and $92,826,846 in 2022 and 2021, respectively, which are included in amounts recoverable from reinsurers in the financial statements. The Company recorded a receivable related to GAE and CAE of $17,535,151 and $15,885,403 in 2022 and 2021, respectively, which are included in other amounts receivable under reinsurance contracts in the financial statements. The Company recorded a payable to UHIC for premiums ceded of $166,835,875 and $126,680,582 as of December 31, 2022 and 2021, respectively, which are included in ceded reinsurance premiums payable in the financial statements. The Company also has an insolvency-only reinsurance agreement. Fees related to this agreement, which are calculated based on a percentage of earned premiums, of $3,932,339 and $3,397,000 in 2022 and 2021, respectively, are netted against net premium income in the financial statements. The Company recorded a payable to UHIC for premiums ceded related to the insolvency agreement of $341,587 and $316,377 in 2022 and 2021, respectively, which are included in ceded reinsurance premiums payable in the financial statements. This agreement also provides for reserve cap protection. Reinsurance contracts do not relieve the Company from its obligations to policyholders. Failure of reinsurers to honor their obligations could result in losses to the Company.

The Company does not have any external reinsurance agreements in place as of December 31, 2022 or 2021. The effect of the internal reinsurance agreements outlined above on net premium income, change in reserve for rate credits, hospital and medical expenses, GAE, and CAE is presented below:

	2022	2021
Premiums:		
Direct	$ 3,976,327,036	$ 3,400,693,198
Ceded:		
Affiliate	1,713,460,483	1,354,915,927
Net premium income	$ 2,262,866,553	$ 2,045,777,271
Change in reserve for rate credits:		
Direct	$ (62,649,672)	$ (2,191,920)
Ceded:		
Affiliate	36,641,402	1,926,669
Net change in reserve for rate credits	$ (26,008,270)	$ (265,251)
Hospital and medical expenses:		
Direct	$ 3,240,619,949	$ 2,775,335,353
Ceded:		
Affiliate	1,387,801,902	1,087,369,469
Net hospital and medical expenses	$ 1,852,818,047	$ 1,687,965,884
General administrative expenses and claims adjustment expenses:		
Direct	$ 361,877,570	$ 337,380,893
Ceded:		
Affiliate	169,304,541	145,514,774
Net general administrative expenses and claims adjustment expenses	$ 192,573,029	$ 191,866,119

A. Ceded Reinsurance Report

Section 1 — General Interrogatories

(1) Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes ( ) No (X)

(2) Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor, or any other person not primarily engaged in the insurance business?

Yes ( ) No (X)

Section 2 — Ceded Reinsurance Report — Part A

(1) Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credit?

Yes ( ) No (X)

(2) Does the reporting entity have any reinsurance agreements in effect that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

Yes ( ) No (X)

Section 3 — Ceded Reinsurance Report — Part B

(1) What is the estimated amount of the aggregate reduction in surplus (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of all reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

The Company estimates there should be no aggregate reduction in surplus for termination of all reinsurance agreements as of December 31, 2022.

(2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes ( ) No (X)

B. Uncollectible Reinsurance — During 2022 and 2021, there were no uncollectible reinsurance recoverables.

C. Commutation of Ceded Reinsurance — There was no commutation of reinsurance in 2022 or 2021.

D. Certified Reinsurer Rating Downgraded or Status Subject to Revocation — Not applicable.

E. Reinsurance Credit

(1) The Company has no ceding reinsurance contracts subject to Appendix A-791 — *Life and Health Reinsurance Agreements* ("A-791") that includes a provision which limits the reinsurer's assumption of significant risk.

(2) The Company has no ceding reinsurance contracts not subject to A-791, for which reinsurance accounting was applied and which include a provision that limits the reinsurer's assumption of risk.

(3) The Company's reinsurance contracts do not contain features which result in delays in payment in form or in fact.

(4) The Company has not reflected a reinsurance accounting credit for any assumption reinsurance contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk transfer requirements of SSAP No. 61R, *Life, Deposit-Type, and Accident and Health Reinsurance* ("SSAP No. 61R").

(5) The Company did not cede any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract during the period covered by these financial statements, for which the statutory accounting treatment and GAAP accounting treatment were not the same.

(6) The Company's ceded reinsurance contracts which are not subject to A-791 and not yearly renewable term reinsurance, are treated the same for GAAP and statutory accounting principles.

24. RETROSPECTIVELY RATED CONTRACTS AND CONTRACTS SUBJECT TO REDETERMINATION

A. The Company estimates accrued retrospective premium adjustments for its group health insurance business based on mathematical calculations in accordance with contractual terms.

B. Estimated accrued retrospective premiums due to (from) the Company are recorded in premiums and considerations and aggregate health policy reserves in the financial statements and as an adjustment to change in reserve for rate credits in the financial statements.

C. Pursuant to the ACA, the Company's commercial and Medicare business is subject to retrospectively rated features based on the actual MLR experienced on the commercial and Medicare lines of business and redetermination features for premium adjustments for changes to each member's health scores based on guidelines determined by the ACA. The total amount of direct premiums written for which a portion is subject to the retrospectively rated and redetermination are $23,245 and $23,149, and $1,130,090,889 and $1,148,395,679, representing less than 1%, and 28% and 34% of total direct premiums written as of December 31, 2022 and December 31, 2021, respectively.

The Company has Medicare Part D risk-corridor amounts from CMS which are subject to a retrospectively rated feature. The Company has estimated accrued retrospective premiums related to certain Part D premiums based on guidelines determined by CMS. The formula is tiered and based on the bid MLR. The amount of Medicare Part D direct premiums written subject to the

retrospectively rated feature was $53,857,251 and $57,205,131, representing 1% and 2% of total direct premiums written as of December 31, 2022 and 2021, respectively.

The Company's KanCare program is subject to retrospectively rated features based on the actual MLR experiences on the Medicaid line of business. The formula is calculated pursuant to the terms outlined in the KanCare contract. The total amount of direct premiums written from the Medicaid contract for which a portion is subject to the retrospectively rated features was $1,585,760,760 and $1,487,482,246, representing 40% and 44% of total direct premiums written as of December 31, 2022 and 2021, respectively.

The KanCare contract, including CHIP, with the State of Kansas includes a provision for which a stated percentage of total direct premiums written can be eligible for a performance guarantee payment, based on various quality measures. The total amount of direct premiums written from the Medicaid contract, including CHIP, for which a portion is subject to the redetermination feature was $49,705,851 and $45,110,004, representing 1% of total direct premiums written as of December 31, 2022 and 2021, respectively.

The Company's HealthNet Program is subject to retrospectively rated features based on actual medical loss ratio experiences on the Medicaid line of business. The formula is calculated pursuant to the terms outlined in the HealthNet contract. The total amount of direct premiums written from the Medicaid contract for which a portion is subject to the retrospectively rated feature was $1,260,452,141 and $764,792,124, representing 32% and 22% of total direct premiums written as of December 31, 2022 and 2021, respectively.

The HealthNet contract, including CHIP, with the State of Missouri includes a provision for which a stated percentage of total direct premiums written can be eligible for a performance guarantee payment, based on various quality measures. The total amount of direct premiums written from the Medicaid contract, including CHIP, for which a portion is subject to the redetermination feature was $30,611,327 and $20,336,434, representing 1% of total direct premiums written as of December 31, 2022 and 2021, respectively.

D. The Company is required to maintain specific minimum loss ratio on the comprehensive commercial and Medicare lines of business.

The following table discloses the minimum MLR rebate liability for the Medicare line of business which is included in aggregate health policy reserves in the financial statements for the years ended December 31, 2022 and 2021:

	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Other Categories with Rebates	5 Total
Prior reporting year					
(1) Medical loss ratio rebates incurred	$ -	$ -	$ -	$ (1,132,746)	$ (1,132,746)
(2) Medical loss ratio rebates paid	-	-	-	2,912,507	2,912,507
(3) Medical loss rebates unpaid	-	-	-	4,287,662	4,287,662
(4) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(5) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(6) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	4,287,662
Current reporting year-to-date					
(7) Medical loss ratio rebates incurred	-	-	-	-	-
(8) Medical loss ratio rebates paid	-	-	-	4,287,662	4,287,662
(9) Medical loss rebates unpaid	-	-	-	-	-
(10) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(11) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(12) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	-

Pursuant to the Medicaid Managed Care Rule, based on Missouri and Kansas's election and states contractual minimum loss ratio requirements, the Company is required to maintain specific MLRs on its HealthNet and KanCare populations. The Company has estimated $6,088,692 and $3,956,881 in estimated Medicaid Managed Care Rule and state MLR rebates on its HealthNet population as of December 31, 2022 and December 31, 2021, respectively, which is included in aggregate health policy reserves. The Company's actual MLR for the Medicaid Managed Care Rule and state contractual requirements for the KanCare population were in excess of the minimum requirements and as a result, no MLR liability was required as of December 31, 2022 and December 31, 2021, respectively.

E. Risk-Sharing Provisions of the Affordable Care Act

(1) The Company has accident and health insurance premiums in 2022 and 2021 subject to the risk-sharing provisions of the ACA.

The ACA imposed fees and premium stabilization provisions on health insurance issuers offering comprehensive commercial health insurance. The three premium stabilization programs are commonly referred to as the 3Rs — risk adjustment, reinsurance, and risk corridors.

Risk Adjustment — The risk adjustment program is a permanent program designed to mitigate the potential impact of adverse selection that generally applies to non-grandfathered individual and small group plans inside and outside of exchanges. The program helps to stabilize market premiums by transferring funds from plans with relatively low-risk enrollees to plans with relatively high-risk enrollees. The data used by CMS to determine the risk adjustment transfer amount is subject to audits along with the true-up to the final CMS report, which may result in a material change to arrive at the final risk adjustment amount from the initial risk adjustment estimate recorded. Premium adjustments pursuant to the risk adjustment program are accounted for as premium subject to redetermination and user fees are accounted for as assessments.

Reinsurance and Risk Corridors — The transitional reinsurance program and risk corridors program were temporary programs which expired at the end of 2016. The details of the years impacted and the amounts received are included in Note 24E 4 and Note 24E 5 below.

(2) The Company has accident and health insurance premiums in 2022 and 2021 subject to the ACA risk-sharing provisions but has no balances as indicated in the table below due to immateriality of the amounts.

		December 31, 2022
a.	**Permanent ACA Risk Adjustment Program**	
	Assets	
1.	Premium adjustments receivable due to ACA Risk Adjustment (including high-risk pool payments)	$ -
	Liabilities	
2.	Risk adjustment user fees payable for ACA Risk Adjustment	-
3.	Premium adjustments payable due to ACA Risk Adjustment (including high-risk pool premium)	-
	Operations (Revenue & Expense)	
4.	Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment	-
5.	Reported in expenses as ACA Risk Adjustment user fees (incurred/paid)	-
b.	**Transitional ACA Reinsurance Program**	
	Assets	
1.	Amounts recoverable for claims paid due to ACA Reinsurance	$ -
2.	Amounts recoverable for claims unpaid due to ACA Reinsurance (Contra Liability)	-
3.	Amounts receivable relating to uninsured plans for contributions for ACA Reinsurance	-
	Liabilities	
4.	Liabilities for contributions payable due to ACA Reinsurance - not reported as ceded premium	-
5.	Ceded reinsurance premiums payable due to ACA Reinsurance	-
6.	Liabilities for amounts held under uninsured plans contributions for ACA Reinsurance	-
	Operations (Revenue & Expense)	
7.	Ceded reinsurance premiums due to ACA Reinsurance	-
8.	Reinsurance recoveries (income statement) due to ACA reinsurance payments or expected payments	-
9.	ACA Reinsurance contributions - not reported as ceded premium	-
c.	**Temporary ACA Risk Corridors Program**	
	Assets	
1.	Accrued retrospective premium due to ACA Risk Corridors	$ -
	Liabilities	
2.	Reserve for rate credits or policy experience rating refunds due to ACA Risk Corridors	-
	Operations (Revenue & Expense)	
3.	Effect of ACA Risk Corridors on net premium income (paid/received)	-
4.	Effect of ACA Risk Corridors on change in reserves for rate credits	-

(3) The following table is a rollforward of the prior year ACA risk-sharing provisions for asset and liability balances, along with reasons for adjustments to prior year balances:

	Accrued during the Prior Year on Business Written before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 - 3)	Prior Year Accrued Less Payments (Col 2 - 4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1 - 3 + 7)	Cumulative Balance from Prior Years (Col 2 - 4 + 8)
	1 Receivable	2 (Payable)	3 Receivable	4 (Payable)	5 Receivable	6 (Payable)	7 Receivable	8 (Payable)	Ref	9 Receivable	10 (Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustment receivable (including high-risk pool payments)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	A	$ -	$ -
2. Premium adjustment (payable) (including high-risk pool premium)	-	-	-	-	-	-	-	-	B	-	-
3. Subtotal ACA Permanent Risk Adjustment Program	-	-	-	-	-	-	-	-		-	-
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	-	-	-	-	-	-	-	-	C	-	-
2. Amounts recoverable for claims unpaid (contra liability)	-	-	-	-	-	-	-	-	D	-	-
3. Amounts receivable relating to uninsured plans	-	-	-	-	-	-	-	-	E	-	-
4. Liabilities for contributions payable due to ACA Reinsurance — not reported as ceded premium	-	-	-	-	-	-	-	-	F	-	-
5. Ceded reinsurance premiums payable	-	-	-	-	-	-	-	-	G	-	-
6. Liability for amounts held under uninsured plans	-	-	-	-	-	-	-	-	H	-	-
7. Subtotal ACA Transitional Reinsurance Program	-	-	-	-	-	-	-	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	I	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	J	-	-
3. Subtotal ACA Risk Corridors Program	-	-	-	-	-	-	-	-		-	-
d. Total for ACA Risk-Sharing Provisions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -

Explanation of Adjustments

A. N/A
B. N/A
C. N/A
D. N/A
E. N/A
F. N/A
G. N/A
H. N/A
I. N/A
J. N/A

(4) The Company does not have any risk corridor receivables or payables to present in the table below.

Risk Corridors Program Year	Accrued during the Prior Year on Business Written before December 31 of the Prior Year 1 Receivable	2 (Payable)	Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year 3 Receivable	4 (Payable)	Differences Prior Year Accrued Less Payments (Col 1 - 3) 5 Receivable	Prior Year Accrued Less Payments (Col 2 - 4) 6 (Payable)	Adjustments To Prior Year Balances 7 Receivable	To Prior Year Balances 8 (Payable)	Ref	Unsettled Balances as of the Reporting Date Cumulative Balance from Prior Years (Col 1 - 3 + 7) 9 Receivable	Cumulative Balance from Prior Years (Col 2 - 4 + 8) 10 (Payable)
a. 2014											
1. Accrued retrospective premium	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	A	$ -	$ -
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	B	-	-
b. 2015											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	C	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	D	-	-
c. 2016											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	E	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	F	-	-
d. Total for Risk Corridors	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -

Explanation of Adjustments

A. N/A
B. N/A
C. N/A
D. N/A
E. N/A
F. N/A

(5) The following table discloses ACA risk corridor receivable balances by risk corridor program year:

Risk Corridors Program Year	1 Estimated Amount to be Filed or Final Amount Filed with CMS	2 Non-Accrued Amounts for Impairment or Other Reasons	3 Amounts Received from CMS	4 Asset Balance (Gross of Non-Admissions) (1 - 2 - 3)	5 Non-Admitted Amount	6 Net Admitted Asset (4 - 5)
a. 2014	$ -	$ -	$ -	$ -	$ -	$ -
b. 2015	115,915	-	115,915	-	-	-
c. 2016	157,039	-	157,039	-	-	-
d. Total (a + b + c)	$ 272,954	$ -	$ 272,954	$ -	$ -	$ -

25. CHANGE IN INCURRED CLAIMS AND CLAIMS ADJUSTMENT EXPENSES

A. Changes in estimates related to the prior year incurred claims are included in total hospital and medical expenses in the current year in the financial statements. The following tables disclose paid claims, incurred claims, and the balance in claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, health care receivables (excluding provider loans and advances not yet expensed) and reinsurance recoverables for the years ended December 31, 2022 and 2021:

	2022		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (89,231,301)	$ (89,231,301)
Paid claims — net of health care receivables* and reinsurance recoveries collected	1,910,648,017	(75,183,018)	1,835,464,999
End of year claim reserve	135,367,854	5,768,690	141,136,544
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	2,046,015,871	(158,645,629)	1,887,370,242
Beginning of year health care receivables* and reinsurance recoverables	-	158,484,701	158,484,701
End of year health care receivables* and reinsurance recoverables	(193,483,091)	446,195	(193,036,896)
Total incurred claims	$ 1,852,532,780	$ 285,267	$ 1,852,818,047

*Health care receivables excludes provider loans and advances not yet expensed of $0 and $15,000 for 2022 and 2021, respectively.

	2021		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (126,190,104)	$ (126,190,104)
Paid claims — net of health care receivables* and reinsurance recoveries collected	1,770,346,237	(20,290,542)	1,750,055,695
End of year claim reserve	84,312,118	4,919,183	89,231,301
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	1,854,658,355	(141,561,463)	1,713,096,892
Beginning of year health care receivables* and reinsurance recoverables	-	133,373,693	133,373,693
End of year health care receivables* and reinsurance recoverables	(155,695,451)	(2,789,250)	(158,484,701)
Total incurred claims	$ 1,698,962,904	$ (10,977,020)	$ 1,687,985,884

*Health care receivables excludes provider loans and advances not yet expensed of $15,000 and $30,000 for 2021 and 2020, respectively.

The liability for claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, net of health care receivables (excluding provider loans and advances not yet expensed), and reinsurance recoverables as of December 31, 2021 was ($69,253,400). As of December 31, 2022, ($75,183,018) has been paid for incurred claims attributable to insured

events of prior years. Reserves remaining for prior years, net of health care receivables (excluding provider loans and advances not yet expensed) and reinsurance recoverables are now $6,214,885, as a result of re-estimation of unpaid claims. Therefore, there has been $285,267 unfavorable prior year development since December 31, 2021 to December 31, 2022. The primary drivers consist of unfavorable development of $14,188,503 in retroactivity for inpatient, outpatient, physician, and pharmacy claims, unfavorable development of $2,706,977 in pharmacy rebates, and unfavorable development of $366,191 in Medicare Part D, offset by favorable development of $5,099,981 in reinsurance, favorable development as a result of a change in the provision for adverse deviations in experience of $4,606,218, favorable development of $4,355,198 in capitation, favorable development of $1,373,132 in withholds, favorable development of $1,071,318 in provider settlements, favorable development of $267,523 in risk share, and favorable development of $167,203 in audit recovery operations gross recoveries. At December 31, 2021, the Company recorded $10,977,020 of favorable development. The primary drivers consist of favorable development of $19,489,299 in retroactivity for inpatient, outpatient, physician, and pharmacy claims and favorable development as a result of a change in the provision for adverse deviations in experience of $7,921,925, offset by $7,924,461 unfavorable development in reinsurance, unfavorable development of $7,356,836 in capitation, and $2,366,604 unfavorable development in accruals for other miscellaneous benefits. Original estimates are increased or decreased, as additional information becomes known regarding individual claims, which could have an impact to the accruals for MLR rebates and retrospectively rated contracts. As a result of the prior year effects, on a regular basis, the Company adjusts revenue and the corresponding liability and receivable related to retrospectively rated policies and the impact of the change is included as a component of change in reserve for rate credits in the financial statements.

The Company incurred CAE of $57,202,281 and $60,864,494 in 2022 and 2021, respectively. These costs are included in the management service fees paid by the Company to UHS as a part of the Agreement (see Note 10). The following table discloses paid CAE, incurred CAE, and the balance in unpaid CAE reserve for 2022 and 2021:

	2022	2021
Total claims adjustment expenses	$ 57,202,281	$ 60,864,494
Less: current year unpaid claims adjustment expenses	(3,897,375)	(2,431,339)
Add: prior year unpaid claims adjustment expenses	2,431,339	2,329,097
Total claims adjustment expenses paid	$ 55,736,245	$ 60,762,252

B. The Company did not make any significant changes in methodologies and assumptions used in the calculation of the liability for claims unpaid and unpaid CAE in 2022.

26. INTERCOMPANY POOLING ARRANGEMENTS

A–G. The Company did not have any intercompany pooling arrangements in 2022 or 2021.

27. STRUCTURED SETTLEMENTS

A–B. The Company did not have structured settlements in 2022 or 2021.

28. HEALTH CARE RECEIVABLES

A. Pharmacy rebates receivable are recorded when reasonably estimated or billed by the affiliated pharmaceutical benefit manager in accordance with pharmaceutical rebate contract provisions. Information used to support rebates billed to the manufacturer is based on utilization information gathered by the pharmaceutical benefit manager and adjusted for significant changes in pharmaceutical contract provisions.

The Company evaluates the admissibility of all pharmacy rebates receivable based on the administration of each underlying pharmaceutical benefit management agreement. The Company has nonadmitted and excluded all pharmacy rebates receivable that do not meet the admissibility criteria of SSAP No. 84, *Health Care and Government Insured Plan Receivables* ("SSAP No. 84") from the financial statements.

For each pharmaceutical management agreement for which a portion of the total pharmacy rebates receivable can be admitted based on the admissibility criteria of SSAP No. 84, the pharmacy rebate transaction history is summarized as follows:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received within 90 Days of Billing	Actual Rebates Received within 91 to 180 Days of Billing	Actual Rebates Received More than 180 Days after Billing
12/31/2022	$ 34,669,138	$ 11,503,464	$ -	$ -	$ -
9/30/2022	36,050,981	36,400,990	23,064,404	-	-
6/30/2022	37,177,790	37,936,592	30,902,269	4,817,807	-
3/31/2022	37,352,733	38,658,171	31,548,781	4,655,824	847,643
12/31/2021	42,636,269	41,702,358	36,297,409	4,939,126	218,151
9/30/2021	40,510,277	40,050,327	36,910,093	2,315,655	613,131
6/30/2021	38,429,030	37,254,060	32,499,623	4,325,388	184,289
3/31/2021	33,653,574	32,432,796	26,333,295	5,322,680	705,227
12/31/2020	27,553,139	26,954,540	22,680,823	3,829,519	418,709
9/30/2020	25,441,589	24,964,414	21,035,935	3,433,730	469,713
6/30/2020	24,816,024	24,023,586	20,419,835	3,361,768	305,267
3/31/2020	22,708,365	21,728,830	8,879,536	12,990,064	31,508

Of the amount reported as health care receivable, $47,250,599 and $57,554,032 relates to pharmacy rebates receivable as of December 31, 2022 and 2021, respectively. This change is primarily due to the decrease in Medicare membership and the change in generic/name brand mix.

B. The Company has nonadmitted all risk-sharing receivables from the financial statements.

The Company also admitted $1,308,189 and $135,528 of provider receivables resulting from claim overpayments as of December 31, 2022 and December 31, 2021, respectively, which are included in health care receivables in the financial statements.

29. PARTICIPATING POLICIES

The Company did not have any participating contracts in 2022 or 2021.

30. PREMIUM DEFICIENCY RESERVES

The following table summarizes the Company's PDR as of December 31, 2022 and 2021:

	2022
1. Liability carried for premium deficiency reserves	$ 1,889
2. Date of the most recent evaluation of this liability	12/31/2022
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

	2021
1. Liability carried for premium deficiency reserves	$ 1,889
2. Date of the most recent evaluation of this liability	12/31/2021
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

PDR is included in aggregate health policy reserves in the financial statements.

31. ANTICIPATED SALVAGE AND SUBROGATION

Due to the type of business being written, the Company has no salvage. As of December 31, 2022 and 2021, the Company had no specific accruals established for outstanding subrogation, as it is considered a component of the actuarial calculations used to develop the estimates of claims unpaid and aggregate health claim reserves.

* * * * * *

SUPPLEMENTAL SCHEDULES

EXHIBIT I:
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2022
(To Be Filed by April 1)

Of The UnitedHealthcare of the Midwest, Inc.

ADDRESS (City, State and Zip Code) Minnetonka , MN 55343

NAIC Group Code 0707 NAIC Company Code 96385 Federal Employer's Identification Number (FEIN) 43-1361841

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 717,477,282

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	FNMA	Bonds	$ 5,733,139	0.8 %
2.02	FHLMC	Bonds	$ 2,507,631	0.3 %
2.03	Northern Inst - BGSXX	Cash Equivalents	$ 1,159,628	0.2 %
2.04	EDISON INTL	Bonds	$ 916,450	0.1 %
2.05	REGL TRANSPRTN A - TRAN	Bonds	$ 842,241	0.1 %
2.06	GOLDMAN SACHS GP	Bonds	$ 805,000	0.1 %
2.07	W CONTRA COSTA C - GEN	Bonds	$ 742,787	0.1 %
2.08	S FL WTR MGMT DI - CTF	Bonds	$ 739,305	0.1 %
2.09	BANK OF NY MELLO	Bonds	$ 699,925	0.1 %
2.10	REEDY CREEK FL I - GEN	Bonds	$ 695,141	0.1 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

Bonds		1	2	Preferred Stocks		3	4
3.01	NAIC 1	$ 47,828,834	6.7 %	3.07	NAIC 1	$ 0	0.0 %
3.02	NAIC 2	$ 7,963,941	1.1 %	3.08	NAIC 2	$ 0	0.0 %
3.03	NAIC 3	$ 0	0.0 %	3.09	NAIC 3	$ 0	0.0 %
3.04	NAIC 4	$ 0	0.0 %	3.10	NAIC 4	$ 0	0.0 %
3.05	NAIC 5	$ 0	0.0 %	3.11	NAIC 5	$ 0	0.0 %
3.06	NAIC 6	$ 0	0.0 %	3.12	NAIC 6	$ 0	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 0	0.0 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 0	0.0 %
5.02	Countries designated NAIC-2	$ 0	0.0 %
5.03	Countries designated NAIC-3 or below	$ 0	0.0 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1:	$ 0	0.0 %
6.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
6.03	Country 1:	$ 0	0.0 %
6.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1:	$ 0	0.0 %
6.06	Country 2:	$ 0	0.0 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$ 0	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$ 0	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1:	$ 0	0.0 %
9.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$ 0	0.0 %
9.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$ 0	0.0 %
9.06	Country 2:	$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01			$ 0	0.0 %
10.02			$ 0	0.0 %
10.03			$ 0	0.0 %
10.04			$ 0	0.0 %
10.05			$ 0	0.0 %
10.06			$ 0	0.0 %
10.07			$ 0	0.0 %
10.08			$ 0	0.0 %
10.09			$ 0	0.0 %
10.10			$ 0	0.0 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 0	0.0 %
11.03	Canadian-currency-denominated investments	$ 0	0.0 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.0 %
11.05	Unhedged Canadian currency exposure	$ 0	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$ 0	0.0 %
12.04		$ 0	0.0 %
12.05		$ 0	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for 14.02 through 14.05.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.0 %
14.04		$ 0	0.0 %
14.05		$ 0	0.0 %

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06		$ 0	$ 0	$ 0
14.07		$ 0	$ 0	$ 0
14.08		$ 0	$ 0	$ 0
14.09		$ 0	$ 0	$ 0
14.10		$ 0	$ 0	$ 0
14.11		$ 0	$ 0	$ 0
14.12		$ 0	$ 0	$ 0
14.13		$ 0	$ 0	$ 0
14.14		$ 0	$ 0	$ 0
14.15		$ 0	$ 0	$ 0

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.0 %
	Largest three investments in general partnership interests:		
15.03		$ 0	0.0 %
15.04		$ 0	0.0 %
15.05		$ 0	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ 0	0.0 %
16.03		$ 0	0.0 %
16.04		$ 0	0.0 %
16.05		$ 0	0.0 %
16.06		$ 0	0.0 %
16.07		$ 0	0.0 %
16.08		$ 0	0.0 %
16.09		$ 0	0.0 %
16.10		$ 0	0.0 %
16.11		$ 0	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.0 %
16.15	Mortgage loans foreclosed	$ 0	0.0 %
16.16	Restructured mortgage loans	$ 0	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential			Commercial			Agricultural			
	Loan to Value	1	2		3	4		5	6		
17.01	above 95%	$ 0	0.0	%	$ 0	0.0	%	$ 0	0.0	%	
17.02	91 to 95%	$ 0	0.0	%	$ 0	0.0	%	$ 0	0.0	%	
17.03	81 to 90%	$ 0	0.0	%	$ 0	0.0	%	$ 0	0.0	%	
17.04	71 to 80%	$ 0	0.0	%	$ 0	0.0	%	$ 0	0.0	%	
17.05	below 70%	$ 0	0.0	%	$ 0	0.0	%	$ 0	0.0	%	

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ 0	0.0 %
18.03		$ 0	0.0 %
18.04		$ 0	0.0 %
18.05		$ 0	0.0 %
18.06		$ 0	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$ 0	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.0 %
19.04		$ 0	0.0 %
19.05		$ 0	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.0 %	$ 0	$ 0	$ 0
20.02	Repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 0	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ 0	0.0 %
21.03	Other	$ 0	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

EXHIBIT II:
SUMMARY INVESTMENT SCHEDULE

SUMMARY INVESTMENT SCHEDULE

	Investment Categories	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
		1 Amount	2 Percentage of Column 1 Line 13	3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage of Column 5 Line 13
1.	Long-Term Bonds (Schedule D, Part 1):						
	1.01 U.S. governments	4,722,799	4.408	4,722,799	0	4,722,799	4.408
	1.02 All other governments	0	0.000	0	0	0	0.000
	1.03 U.S. states, territories and possessions, etc. guaranteed	1,493,466	1.394	1,493,466	0	1,493,466	1.394
	1.04 U.S. political subdivisions of states, territories, and possessions, guaranteed	2,944,721	2.748	2,944,721	0	2,944,721	2.748
	1.05 U.S. special revenue and special assessment obligations, etc. non-guaranteed	17,139,228	15.996	17,139,228	0	17,139,228	15.996
	1.06 Industrial and miscellaneous	24,500,015	22.865	24,500,015	0	24,500,015	22.865
	1.07 Hybrid securities	0	0.000	0	0	0	0.000
	1.08 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	1.09 SVO identified funds	0	0.000	0	0	0	0.000
	1.10 Unaffiliated bank loans	0	0.000	0	0	0	0.000
	1.11 Unaffiliated certificates of deposit	0	0.000	0	0	0	0.000
	1.12 Total long-term bonds	50,800,229	47.411	50,800,229	0	50,800,229	47.411
2.	Preferred stocks (Schedule D, Part 2, Section 1):						
	2.01 Industrial and miscellaneous (Unaffiliated)	0	0.000	0	0	0	0.000
	2.02 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	2.03 Total preferred stocks	0	0.000	0	0	0	0.000
3.	Common stocks (Schedule D, Part 2, Section 2):						
	3.01 Industrial and miscellaneous Publicly traded (Unaffiliated)	0	0.000	0	0	0	0.000
	3.02 Industrial and miscellaneous Other (Unaffiliated)	0	0.000	0	0	0	0.000
	3.03 Parent, subsidiaries and affiliates Publicly traded	0	0.000	0	0	0	0.000
	3.04 Parent, subsidiaries and affiliates Other	0	0.000	0	0	0	0.000
	3.05 Mutual funds	0	0.000	0	0	0	0.000
	3.06 Unit investment trusts	0	0.000	0	0	0	0.000
	3.07 Closed-end funds	0	0.000	0	0	0	0.000
	3.08 Exchange traded funds	0	0.000	0	0	0	0.000
	3.09 Total common stocks	0	0.000	0	0	0	0.000
4.	Mortgage loans (Schedule B):						
	4.01 Farm mortgages	0	0.000	0	0	0	0.000
	4.02 Residential mortgages	0	0.000	0	0	0	0.000
	4.03 Commercial mortgages	0	0.000	0	0	0	0.000
	4.04 Mezzanine real estate loans	0	0.000	0	0	0	0.000
	4.05 Total valuation allowance	0	0.000	0	0	0	0.000
	4.06 Total mortgage loans	0	0.000	0	0	0	0.000
5.	Real estate (Schedule A):						
	5.01 Properties occupied by company	0	0.000	0	0	0	0.000
	5.02 Properties held for production of income	0	0.000	0	0	0	0.000
	5.03 Properties held for sale	0	0.000	0	0	0	0.000
	5.04 Total real estate	0	0.000	0	0	0	0.000
6.	Cash, cash equivalents and short-term investments:						
	6.01 Cash (Schedule E, Part 1)	51,335	0.048	51,335	0	51,335	0.048
	6.02 Cash equivalents (Schedule E, Part 2)	56,296,904	52.541	56,296,904	0	56,296,904	52.541
	6.03 Short-term investments (Schedule DA)	0	0.000	0	0	0	0.000
	6.04 Total cash, cash equivalents and short-term investments	56,348,239	52.589	56,348,239	0	56,348,239	52.589
7.	Contract loans	0	0.000	0	0	0	0.000
8.	Derivatives (Schedule DB)	0	0.000	0	0	0	0.000
9.	Other invested assets (Schedule BA)	0	0.000	0	0	0	0.000
10.	Receivables for securities	0	0.000	0	0	0	0.000
11.	Securities Lending (Schedule DL, Part 1)	0	0.000	0	XXX	XXX	XXX
12.	Other invested assets (Page 2, Line 11)	0	0.000	0	0	0	0.000
13.	Total invested assets	107,148,468	100.000	107,148,468	0	107,148,468	100.000

OTHER ATTACHMENT

Deloitte.

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To the Audit Committee of
UnitedHealthcare of the Midwest, Inc.
13655 Riverport Drive, MO050-1000
Maryland Heights, MO 63043

The Management of
UnitedHealthcare of the Midwest, Inc.
13655 Riverport Drive, MO050-1000
Maryland Heights, MO 63043

Dear Members of the Audit Committee and Management:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the statutory basis financial statements of UnitedHealthcare of the Midwest, Inc. (the "Company") for the years ended December 31, 2022, and 2021, and have issued our report thereon dated May 11, 2023. In connection therewith, we advise you as follows:

1. We are independent certified public accountants with respect to the Company and conform to the standards of the accounting profession as contained in the *Code of Professional Conduct* and pronouncements of the American Institute of Certified Public Accountants, the rules and regulations of the Missouri Department of Insurance, and the Rules of Professional Conduct of the Florida Board of Accountancy.

2. The engagement partner and engagement manager, who are certified public accountants, have 23 years and 8 years, respectively, of experience in public accounting and are experienced in auditing insurance enterprises. Members of the engagement team, most of whom have had experience in auditing insurance enterprises and 28 percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

3. We understand that the Company intends to file its audited statutory basis financial statements and our report thereon with the Missouri Department of Insurance and other state insurance departments in states in which the Company is licensed and that the insurance commissioners of those states will be relying on that information in monitoring and regulating the statutory basis financial condition of the Company.

   While we understand that an objective of issuing a report on the statutory basis financial statements is to satisfy regulatory requirements, our audit was not planned to satisfy all objectives or responsibilities of insurance regulators. In this context, the Company and insurance commissioners should understand that the objective of an audit of statutory basis financial statements in accordance with auditing standards generally accepted in the United States of America is to form an opinion and issue a report on whether the statutory basis financial statements present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus, results of operations and cash flows in accordance with accounting practices prescribed or permitted by the Missouri Department of Insurance. Consequently, under auditing standards generally accepted in the United States of America, we have the responsibility, within the inherent limitations of the auditing process, to plan and perform our audit to obtain reasonable assurance regarding whether the statutory basis financial statements are free from material misstatement, whether due to error or fraud, and to

exercise due professional care in the conduct of the audit. The Company is not required to have, nor were we engaged to perform, an audit of internal control over financial reporting. Our audit included consideration of internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control over financial reporting. The concept of selective testing of the data being audited, which involves judgment both as to the number of transactions to be audited and the areas to be tested, has been generally accepted as a valid and sufficient basis for an auditor to express an opinion on financial statements. Audit procedures that are effective for detecting errors, if they exist, may be ineffective for detecting misstatements resulting from fraud. Because of the characteristics of fraud, particularly those involving concealment and falsified documentation (including forgery), a properly planned and performed audit may not detect a material misstatement resulting from fraud. In addition, an audit does not address the possibility that material misstatements may occur in the future. Also, our use of professional judgment and the assessment of materiality for the purpose of our audit mean that matters may exist that would have been assessed differently by insurance commissioners.

It is the responsibility of the management of the Company to adopt sound accounting policies, to maintain an adequate and effective system of accounts, and to establish and maintain internal control that will, among other things, provide reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition and that transactions are executed in accordance with management's authorization and are recorded properly to permit the preparation of financial statements in conformity with accounting practices prescribed or permitted by the Missouri Department of Insurance.

The Insurance Commissioner should exercise due diligence to obtain whatever other information that may be necessary for the purpose of monitoring and regulating the statutory basis financial position of insurers and should not rely solely on the independent auditor's report.

4. We will retain the working papers (including those kept in a hard copy or electronic medium) prepared in the conduct of our audit until the Missouri Department of Insurance has filed a Report of Examination covering 2022, but no longer than seven years. After notification to the Company, we will make the working papers available for review by the Missouri Department of Insurance or its delegates, at the offices of the insurer, at our offices, at the Missouri Department of Insurance, or at any other reasonable place designated by the Insurance Commissioner. Furthermore, in the conduct of the aforementioned periodic review by the Missouri Department of Insurance, photocopies of pertinent audit working papers may be made (under the control of Deloitte & Touche LLP) and such copies may be retained by the Missouri Department of Insurance. In addition, to the extent requested, we may provide the Missouri Department of Insurance with copies of certain audit working papers (such as unlocked copies of Excel spreadsheets that do not contain password protection or encryption). As such, these audit working papers will be subject to potential modification by Missouri Department of Insurance or by others. We are not responsible for any modifications made to the copies, electronic or otherwise, after they are provided to the Missouri Department of Insurance; and we are likewise not responsible for any effect that any such modifications, whether intentional or not, might have on the process, substance, or outcome of your regulatory examination.

5. The engagement partner has served in this capacity with respect to the Company since 2019, is licensed by the Florida Board of Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

6. To the best of our knowledge and belief, we are in compliance with the requirements of section 7 of the *NAIC's Model Rule (Regulation) Requiring Annual Audited Financial Reports* regarding qualifications of independent certified public accountants.

This letter is intended solely for the information and use of the Audit Committee and management of UnitedHealthcare of the Midwest, Inc. and for filing with the Missouri Department of Insurance and other state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte & Touche LLP

May 11, 2023

UnitedHealthcare of the Midwest, Inc. – 2021

Audited Financial Statements

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UnitedHealthcare of the Midwest, Inc.

Statutory Basis Financial Statements as of and for the Years Ended December 31, 2021 and 2020, Supplemental Schedules as of and for the Year Ended December 31, 2021, Independent Auditor's Report, and Qualification Letter

UNITEDHEALTHCARE OF THE MIDWEST, INC.

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INDEPENDENT AUDITOR'S REPORT

To the Audit Committee of
UnitedHealthcare of the Midwest, Inc.
13655 Riverport Drive, MO050-1000
Maryland Heights, MO 63043

Opinion

We have audited the statutory basis financial statements of UnitedHealthcare of the Midwest, Inc. (the "Company"), which comprise the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2021 and 2020, and the related statutory basis statements of operations, changes in capital and surplus, and cash flows for the years then ended, and the related notes to the statutory basis financial statements (collectively referred to as the "statutory basis financial statements").

In our opinion, the accompanying statutory basis financial statements present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus of the Company as of December 31, 2021 and 2020, and the results of its operations and its cash flows for the years then ended in accordance with the accounting practices prescribed or permitted by the Missouri Department of Insurance described in Note 1.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Statutory Basis Financial Statements section of our report. We are required to be independent of the Company, and to meet our ethical responsibilities, in accordance with the relevant ethical requirements related to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Statutory Basis of Accounting

We draw attention to Note 1 of the statutory basis financial statements, which describes the basis of accounting. As described in Note 1 to the statutory basis financial statements, the statutory basis financial statements are prepared by the Company using accounting practices prescribed or permitted by the Missouri Department of Insurance, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to meet the requirements of the Missouri Department of Insurance. As a result, the statutory basis financial statements may not be suitable for another purpose. Our opinion is not modified with respect to this matter.

Responsibilities of Management for the Statutory Basis Financial Statements

Management is responsible for the preparation and fair presentation of these statutory basis financial statements in accordance with the accounting practices prescribed or permitted by the Missouri Department of Insurance. Management is also responsible for the design, implementation, and

maintenance of internal control relevant to the preparation and fair presentation of the statutory basis financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the statutory basis financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date that the statutory basis financial statements are issued.

Auditor's Responsibilities for the Audit of the Statutory Basis Financial Statements

Our objectives are to obtain reasonable assurance about whether the statutory basis financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the statutory financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the statutory basis financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the statutory basis financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the statutory basis financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Report on Supplemental Schedules

Our 2021 audit was conducted for the purpose of forming an opinion on the 2021 statutory basis financial statements as a whole. The supplemental investment risks interrogatories and the summary investment schedule as of and for the year ended December 31, 2021 are presented for purposes of additional analysis and are not a required part of the 2021 statutory basis financial statements. These

schedules are the responsibility of the Company's management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory basis financial statements. Such schedules have been subjected to the auditing procedures applied in our audit of the 2021 statutory basis financial statements and certain additional procedures, including comparing and reconciling such schedules directly to the underlying accounting and other records used to prepare the statutory basis financial statements or to the statutory basis financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such schedules are fairly stated in all material respects in relation to the 2021 statutory basis financial statements as a whole.

Restriction on Use

Our report is intended solely for the information and use of the Audit Committee and the management of the Company and for filing with state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte & Touche LLP

April 21, 2022

UNITEDHEALTHCARE OF THE MIDWEST, INC.

STATUTORY BASIS STATEMENTS OF ADMITTED ASSETS, LIABILITIES, AND CAPITAL AND SURPLUS AS OF DECEMBER 31, 2021 AND 2020

	2021	2020
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$ 51,206,078	$ 52,061,919
Cash of $253,849 and $38,778 and cash equivalents of $57,799,537 and $128,441,832, in 2021 and 2020, respectively	58,053,386	128,480,610
Subtotal cash and invested assets	109,259,464	180,542,529
OTHER ASSETS:		
Investment income due and accrued	379,658	398,125
Premiums and considerations	273,310,031	222,628,945
Amounts recoverable from reinsurers	92,826,846	89,645,722
Other amounts receivable under reinsurance contracts	15,885,403	15,418,689
Amounts receivable relating to uninsured plans	39,672,386	19,414,184
Current federal income tax recoverable	-	1,594,260
Net deferred tax asset	1,697,772	1,751,172
Health care receivables	58,674,479	37,111,080
Subtotal other assets	482,446,575	387,962,177
TOTAL ADMITTED ASSETS	$ 591,706,039	$ 568,504,706
LIABILITIES, CAPITAL AND SURPLUS		
LIABILITIES:		
Claims unpaid	$ 85,938,855	$ 120,307,812
Accrued medical incentive pool and bonus amounts	2,315,738	4,782,607
Unpaid claims adjustment expenses	2,431,339	2,329,097
Aggregate health policy reserves, including $4,287,662 and $8,332,915 for medical loss ratio rebate per the Public Health Service Act for 2021 and 2020, respectively	44,766,631	41,617,550
Aggregate health claim reserves	976,708	1,099,685
Premiums received in advance	123	400
General expenses due or accrued	5,107,080	15,034,054
Current federal income tax payable	2,287,104	-
Ceded reinsurance premiums payable	126,996,959	106,955,401
Remittances and items not allocated	9,325	4,134
Amounts due to parent, subsidiaries, and affiliates	16,647,481	18,178,607
Liability for amounts held under uninsured plans	1,149,255	1,767,624
Other liabilities	6,984	3,213
Total liabilities	288,633,582	312,080,184
CAPITAL AND SURPLUS:		
Common capital stock, $1 par value — 100 shares authorized; 1 share issued and outstanding	1	1
Gross paid-in and contributed surplus	32,788,535	32,788,535
Unassigned surplus	270,283,921	223,635,986
Total capital and surplus	303,072,457	256,424,522
TOTAL LIABILITIES, CAPITAL AND SURPLUS	$ 591,706,039	$ 568,504,706

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDWEST, INC.

STATUTORY BASIS STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2021 AND 2020

	2021	2020
REVENUES:		
Net premium income	$ 2,045,777,271	$ 1,575,204,977
Change in reserve for rate credits	(265,251)	(2,180,798)
Total revenues	2,045,512,020	1,573,024,179
UNDERWRITING DEDUCTIONS:		
Hospital and medical:		
Hospital/medical benefits	2,492,828,718	1,997,638,320
Other professional services	73,391,605	66,306,784
Prescription drugs	203,594,773	168,700,457
Incentive pool, withhold adjustments, and bonus amounts	5,540,257	11,819,933
Net reinsurance recoveries	(1,087,369,469)	(994,673,161)
Total hospital and medical	1,687,985,884	1,249,792,333
Claims adjustment expenses	60,864,494	70,100,168
General administrative expenses	131,001,625	125,474,687
Increase (decrease) in reserves for accident and health contracts	1,889	(1,151,000)
Total underwriting deductions	1,879,853,892	1,444,216,188
NET UNDERWRITING GAIN	165,658,128	128,807,991
NET INVESTMENT GAINS:		
Net investment income earned	1,248,000	1,842,243
Net realized capital gains (losses) less capital gains tax (benefit) of $37,111 and $(6,451) in 2021 and 2020, respectively	139,607	(24,267)
Total net investment gains	1,387,607	1,817,976
NET GAIN (LOSS) FROM AGENTS OR PREMIUM BALANCES CHARGED OFF	17,639	(510,353)
OTHER LOSSES	(133,987)	(786,219)
NET INCOME BEFORE FEDERAL INCOME TAXES	166,929,387	129,329,395
FEDERAL INCOME TAXES INCURRED	34,874,994	34,356,191
NET INCOME	$ 132,054,393	$ 94,973,204

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDWEST, INC.

STATUTORY BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2021 AND 2020

	Section 9010 Affordable Care Act ("ACA") Subsequent Fee Year Assessment	Common Capital Stock Shares	Common Capital Stock Amount	Gross Paid-In and Contributed Surplus	Unassigned Surplus	Total Capital and Surplus
BALANCE — January 1, 2020	$ 34,403,481	1	$ 1	$ 32,788,535	$ 135,724,818	$ 202,916,835
Net income	-	-	-	-	94,973,204	94,973,204
Change in net deferred income taxes	-	-	-	-	(688,795)	(688,795)
Change in nonadmitted assets	-	-	-	-	2,423,278	2,423,278
Cash dividends to parent	-	-	-	-	(43,200,000)	(43,200,000)
Section 9010 ACA subsequent fee year assessment	(34,403,481)	-	-	-	34,403,481	-
BALANCE — December 31, 2020	-	1	1	32,788,535	223,635,986	256,424,522
Net income	-	-	-	-	132,054,393	132,054,393
Change in net deferred income taxes	-	-	-	-	(53,400)	(53,400)
Change in nonadmitted assets	-	-	-	-	(353,058)	(353,058)
Cash dividends to parent	-	-	-	-	(85,000,000)	(85,000,000)
BALANCE — December 31, 2021	$ -	1	$ 1	$ 32,788,535	$ 270,283,921	$ 303,072,457

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDWEST, INC.

STATUTORY BASIS STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2021 AND 2020

	2021	2020
CASH FLOWS FROM OPERATIONS:		
Premiums collected, net of reinsurance	$ 2,018,022,476	$ 1,564,536,907
Net investment income	1,732,722	2,388,670
Benefit and loss related payments	(1,750,055,695)	(1,265,571,093)
Commissions and other expenses paid	(223,161,915)	(174,336,565)
Federal income taxes paid, net	(31,030,741)	(41,865,188)
Net cash provided by operations	15,506,847	85,152,731
CASH FLOWS FROM INVESTMENTS:		
Proceeds from investments sold, matured or repaid:		
Bonds	8,956,625	7,991,352
Total investment proceeds	8,956,625	7,991,352
Cost of investments acquired:		
Bonds	(8,383,537)	(9,574,751)
Total investments acquired	(8,383,537)	(9,574,751)
Net cash provided by (used in) investments	573,088	(1,583,399)
CASH FLOWS FROM FINANCING AND MISCELLANEOUS ACTIVITIES:		
Cash (used in) provided by net transfers (to) from affiliates	(1,531,126)	19,184,441
Dividends paid	(85,000,000)	(43,200,000)
Other cash provided	23,967	25,341
Net cash used in financing and miscellaneous activities	(86,507,159)	(23,990,218)
RECONCILIATION OF CASH AND CASH EQUIVALENTS:		
NET CHANGE IN CASH AND CASH EQUIVALENTS	(70,427,224)	59,579,114
CASH AND CASH EQUIVALENTS — Beginning of year	128,480,610	68,901,496
CASH AND CASH EQUIVALENTS — End of year	$ 58,053,386	$ 128,480,610

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDWEST, INC.

NOTES TO STATUTORY BASIS FINANCIAL STATEMENTS
AS OF AND FOR THE YEARS ENDED DECEMBER 31, 2021 AND 2020

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GOING CONCERN

Organization and Operation

UnitedHealthcare of the Midwest, Inc. (the "Company"), licensed as a health maintenance organization ("HMO"), offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. The Company is a wholly owned subsidiary of UnitedHealthcare, Inc. ("UHC"). UHC is a wholly owned subsidiary of United HealthCare Services, Inc. ("UHS"), a management corporation that provides services to the Company under the terms of a management agreement (the "Agreement"). UHS is a wholly owned subsidiary of UnitedHealth Group Incorporated ("UnitedHealth Group"). UnitedHealth Group is a publicly held company trading on the New York Stock Exchange.

The Company was incorporated on February 26, 1985, as an HMO and operations commenced in August 1985. The Company is certified as an HMO by the Missouri Department of Insurance (the "Department"). The Company has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees. As of December 31, 2021, the Company is licensed in five states.

The Company offers comprehensive commercial products to individuals. Each contract outlines the coverage provided and renewal provisions.

The Company serves as a plan sponsor offering a Dual Special Needs Plan (the "Medicare Plan") under a contract with the Centers for Medicare and Medicaid Services ("CMS").

The Company has a contract with the State of Kansas Department of Health and Environment ("KDHE"), to provide health care services to Medicaid and Children's Health Insurance Program ("CHIP", a program for uninsured children) eligible beneficiaries in Kansas. The current contract is effective until December 31, 2023.

The Company has a contract with the State of Missouri Department of Social Services, Missouri HealthNet Division ("HealthNet"), to provide health care services to Medicaid and CHIP eligible beneficiaries in Missouri. The current contract is effective through June 30, 2022, and is subject to annual renewal provisions thereafter.

A. Accounting Practices

The statutory basis financial statements (herein referred to as "financial statements") are presented on the basis of accounting practices prescribed or permitted by the Department.

The Department recognizes only statutory accounting practices, prescribed or permitted by the State of Missouri (the "State"), for determining and reporting the financial condition and results of operations of an HMO, for determining its solvency under Missouri Insurance Law. The State prescribes the use of the National Association of Insurance Commissioners' ("NAIC") Accounting Practices and Procedures manual ("NAIC SAP") in effect for the accounting periods covered in the financial statements.

The Department has adopted certain prescribed accounting practices that differ from those found in the NAIC SAP. A reconciliation of the Company's net income and capital and surplus between the NAIC SAP and practices prescribed by the Department is shown below:

	SSAP #	AFS Line Desc	December 31, 2021	December 31, 2020
Net Income				
(1) Company state basis	XXX	XXX	$ 132,054,393	$ 94,973,204
(2) State prescribed practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(3) State permitted practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	XXX	XXX	$ 132,054,393	$ 94,973,204
Capital and Surplus				
(5) Company state basis	XXX	XXX	$ 303,072,457	$ 256,424,522
(6) State prescribed practices that are an increase/(decrease) from NAIC SAP: 20 CSR 200-1.040(3)(b) — Nonadmit prepaid premium taxes	101	Prepaid premium taxes	(7,241)	(7,241)
(7) State permitted practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(8) NAIC SAP (5 - 6 - 7 = 8)	XXX	XXX	$ 303,079,698	$ 256,431,763

Prepaid premium taxes of $7,241 as of December 31, 2021 and 2020, respectively, are required to be nonadmitted per Missouri Regulation 20 CSR 200-1.040. There was no impact to net income and no regulatory risk-based capital ("RBC") event was triggered from the Company using the Missouri statute.

B. Use of Estimates in the Preparation of the Financial Statements

The preparation of these financial statements in conformity with the NAIC Annual Statement Instructions and the NAIC SAP include certain amounts that are based on the Company's estimates and judgments. These estimates require the Company to apply complex assumptions and judgments, often because the Company must make estimates about the effects of matters that are inherently uncertain and will change in subsequent periods. The most significant estimates relate to hospital and medical benefits, claims unpaid, aggregate health policy reserves (including medical loss ratio ("MLR") rebates and premium deficiency reserves ("PDR")), aggregate health claim reserves, risk corridor, and risk adjustment estimates. The Company adjusts these estimates each period as more current information becomes available. The impact of any changes in estimates is included in the determination of net income in the period in which the estimate is adjusted.

C. Accounting Policy

Basis of Presentation — The Company prepares its financial statements on the basis of accounting practices prescribed or permitted by the Department. These statutory practices differ from accounting principles generally accepted in the United States of America ("GAAP").

The Company has deemed the following to be significant differences between statutory practices and GAAP:

- Certain debt investments categorized as available-for-sale or held-to-maturity under GAAP are presented at the lower of book/adjusted carrying value or fair value in accordance with the NAIC designations in the financial statements, whereas under GAAP, these investments are shown at fair value or book/adjusted carrying value, respectively;

- Cash, cash equivalents, and short-term investments in the financial statements represent cash balances and investments with original maturities of one year or less from the time of acquisition, whereas under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and investments that will mature in one year or less from the balance sheet date;

- The statutory basis statements of cash flows reconcile the corresponding captions of cash, cash equivalents and short-term investments, which can include restricted cash reserves, with original maturities of one year or less from the time of acquisition, whereas under GAAP, the statements of cash flows reconcile the corresponding captions of cash, cash equivalents and restricted cash with maturities of three months or less. Short-term investments with a final maturity of one year or less from the balance sheet date are not included in the reconciliation of GAAP cash flows. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and NAIC SAP. The statutory basis statements of cash flows are prepared in accordance with the NAIC Annual Statement Instructions.

- Reserves ceded to reinsurers for claims unpaid and aggregate health claim reserves have been reported as reductions of the related reserves rather than as assets, which would be required under GAAP.

- Comprehensive income and its components are not separately presented in the financial statements, whereas under GAAP, it is a requirement to present comprehensive income and its components in the financial statements.

Accounting policy disclosures that are required by the NAIC Annual Statement instructions are as follows:

(1–2) Bonds are stated at book/adjusted carrying value if they meet NAIC designation of one or two and stated at the lower of book/adjusted carrying value or fair value if they meet an NAIC designation of three or higher. The Company does not have any mandatory convertible securities or Investment Analysis Office of the NAIC (“IAO”) identified funds (i.e.: exchange traded funds or bond mutual funds) in its bond portfolio. Amortization of bond premium or accretion of discount is calculated using the constant-yield interest method. Bonds are valued and reported using market prices published by the IAO in accordance with the NAIC Valuation of Securities manual prepared by the IAO or an external pricing service;

(3–4) The Company holds no common or preferred stock;

(5) The Company holds no mortgage loans on real estate;

(6) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the book/adjusted carrying value, commonly referred to as amortized cost, of loan-backed securities are based on a three-month constant prepayment rate history

obtained from external data source vendors. The Company's investment policy limits investments in nonagency residential mortgage-backed securities, including home equity and sub-prime mortgages, to 10% of total cash and invested assets. Total combined investments in mortgage-backed securities and asset-backed securities cannot exceed more than 30% of total cash and invested assets;

(7) The Company holds no investments in subsidiaries, controlled, or affiliated entities;

(8) The Company has no investment interests with respect to joint ventures, partnerships, or limited liability companies;

(9) The Company holds no derivatives;

(10) PDR (inclusive of conversion reserves) and the related expenses are recognized when it is probable that expected future health care expenses, claims adjustment expenses ("CAE"), direct administration costs, and an allocation of indirect administration costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries considered over the remaining lives of the contracts, and are recorded as aggregate health policy reserves in the financial statements. Indirect administration costs arise from activities that are not specifically identifiable to a specific group of existing contracts, and therefore, those costs are fully allocated among the various contract groupings. The allocation of indirect administration costs to each contract grouping is made proportionately to the expected margins remaining in the premiums after future health care expenses, CAE and direct administration costs are considered. The data and assumptions underlying such estimates and the resulting reserves are periodically updated, and any adjustments are reflected as an increase (decrease) in reserves for accident and health contracts in the financial statements in the period in which the change in estimate is identified. The Company does anticipate investment income as a factor in the PDR calculation (see Note 30);

(11) CAE are those costs expected to be incurred in connection with the adjustment and recording of accident and health claims. Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to its affiliate, UHS, in exchange for administrative and management services. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and general administrative expenses ("GAE") to be reported in the financial statements. It is the responsibility of UHS to pay CAE in the event the Company ceases operations. The Company has recorded an estimate of unpaid CAE associated with incurred but unpaid claims, which is included in unpaid CAE in the financial statements. Management believes the amount of the liability for unpaid CAE as of December 31, 2021 is adequate to cover the Company's cost for the adjustment and recording of unpaid claims; however, actual expenses may differ from those established estimates. Adjustments to the estimates for unpaid CAE are reflected in operating results in the period in which the change in estimate is identified;

(12) The Company does not carry any fixed assets in the financial statements;

(13) Health care receivables consist of pharmacy rebates receivable estimated based on the most currently available data from the Company's claims processing systems and from data provided by the Company's affiliated pharmaceutical benefit manager, OptumRx, Inc. ("OptumRx"). Health care receivables also include receivables for amounts due to the Company for provider advances and claim overpayments to providers, hospitals and other health care organizations. In addition, the Company has agreements with certain independent physicians and physician network organizations that provide for the establishment of a fund into which the Company places monthly premiums payable for members assigned to the physician. The Company manages the disbursement of funds

from this account as well as reviews the utilization of nonprimary care medical services of members assigned to the physicians. Any deficits in the fund are shared by the Company and the physician based upon predetermined risk-sharing percentages and any associated receivable is included in health care receivables. Health care receivables are considered nonadmitted assets under the NAIC SAP if they do not meet admissibility requirements. Accordingly, the Company has excluded receivables that do not meet the admissibility criteria from the financial statements (see Note 28).

The Company has also deemed the following to be significant accounting policies:

ASSETS

Cash and Invested Assets

- Bonds include securities with a maturity of greater than one year at the time of purchase;

- Cash equivalents include securities that have original maturity dates of three months or less from the date of acquisition. Money-market funds are reported at fair value or net asset value ("NAV") as a practical expedient;

- Realized capital gains and losses on sales of investments are calculated based upon specific identification of the investments sold. These gains and losses are reported as net realized capital gains (losses) less capital gains tax (benefit) ("net realized capital gains (losses) less capital gains tax") in the financial statements;

- The Company continually monitors the difference between amortized cost and estimated fair value of its investments. If any of the Company's investments experience a decline in value that the Company has determined is other-than-temporary, or if the Company has determined it will sell a security that is in an impaired status, the Company will record a realized loss in net realized capital gains (losses) less capital gains taxes. The new cost basis is not changed for subsequent recoveries in fair value. The prospective adjustment method is utilized for loan-backed securities for periods subsequent to the loss recognition (see Note 5).

Other Assets

- **Premiums and Considerations** — The Company reports uncollected premium balances from its insured members, CMS, and state Medicaid agencies as premiums and considerations in the financial statements. Uncollected premium balances that are over 90 days past due, with the exception of amounts due from government insured plans, are considered nonadmitted assets. In addition to those balances, current balances are also considered nonadmitted if the corresponding balance greater than 90 days past due is deemed more than inconsequential. Premiums and considerations also include amounts for CMS risk corridor receivables, CMS risk adjustment receivables for the Medicare Plan, KDHE pay for performance receivables, and HealthNet pay for performance receivables.

  Premium adjustments for the CMS risk corridor program are accounted for as premium adjustments subject to retrospectively rated features (see Note 24). Premium adjustments for the CMS risk adjustment and pay for performance programs are accounted for as premium adjustments subject to redetermination (see Note 24).

- **Amounts Receivable Relating to Uninsured Plans** — The Company reports amounts due to the Company from CMS for the administrative activities it performs for which it has no insurance risk as amounts receivable relating to uninsured plans (see Note 18). Amounts receivable relating to uninsured plans include costs incurred by the Company that

are in excess of the cost reimbursement under the Medicare Plan for the catastrophic reinsurance subsidy and the low-income member cost sharing subsidy and amounts due from the pharmaceutical manufacturers for reimbursement of the discounts under the Patient Protection and Affordable Care Act and its related legislation ("ACA") which mandates consumer discounts on brand name prescription drugs for Part D plan participants in the coverage gap.

LIABILITIES

- **Claims Unpaid and Aggregate Health Claim Reserves** — Claims unpaid and aggregate health claim reserves include claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees have received but for which claims have not yet been submitted, and payments and liabilities for physician, hospital, and other medical costs disputes.

  The estimates for incurred but not yet reported claims are developed using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as historical submission and payment data, cost trends, customer and product mix, seasonality, utilization of health care services, contracted service rates, and other relevant factors. The Company estimates such liabilities for physician, hospital, and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. These estimates may change as actuarial methods change or as underlying facts upon which estimates are based change. The Company did not change actuarial methods during 2021 and 2020. Management believes the amount of claims unpaid and aggregate health claim reserves is a best estimate of the Company's liability for unpaid claims and aggregate health claim reserves as of December 31, 2021; however, actual payments may differ from those established estimates.

  The Company contracts with hospitals, physicians, and other providers of health care under capitated or discounted fee for service arrangements, including a hospital per diem to provide medical care services to enrollees. Some of these contracts are with related parties (see Note 10). Capitated providers are at risk for the cost of medical care services provided to the Company's enrollees; however, the Company is ultimately responsible for the provision of services to its enrollees should the capitated provider be unable to provide the contracted services.

- **Aggregate Health Policy Reserves** — Aggregate health policy reserves includes CMS risk adjustment payables for the Medicare Plan, estimated MLR rebates payable on the Medicare Plan and HealthNet contract, KDHE pay for performance payables, risk corridor payables due to the KDHE, and the estimated amount for PDR.

  Premium adjustments for the estimated MLR rebates and the KDHE risk corridor programs are accounted for as premium adjustments subject to retrospectively rated features (see Note 24). Premium adjustments for the CMS risk adjustment and pay for performance programs are accounted for as premium adjustments subject to redetermination (see Note 24). PDR is specifically outlined in Note 30.

CAPITAL AND SURPLUS AND MINIMUM STATUTORY REQUIREMENTS

- **Restricted Cash Reserves** — The Company is in compliance with the various state regulatory deposit requirements as of December 31, 2021 and 2020, respectively, for qualification purposes as a domestic and foreign insurer. These restricted cash reserves are stated at book/adjusted carrying value, which approximates fair value. These restricted

deposits are included in bonds in the financial statements. Interest earned on these deposits accrues to the Company (see Note 5).

- **Minimum Capital and Surplus** — Under the laws of the State of Missouri, the Company's domiciliary state, the Department requires the Company to maintain a minimum capital and surplus equal to 2% of the prior year net premium income, or $31,504,100 and $24,798,269 as of December 31, 2021 and 2020, respectively.

  RBC is a regulatory tool for measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. The Department requires the Company to maintain minimum capital and surplus equal to the greater of the state statute as outlined above, or the company action level as calculated by the RBC formula, or the level needed to avoid action pursuant to the trend test in the RBC formula.

  The Company is also subject to minimum capital and surplus requirements in other states where it is licensed to do business.

  The Company is in compliance with the minimum required capital and surplus amounts where it is licensed to do business, as of December 31, 2021 and 2020.

STATEMENTS OF OPERATIONS

- **Net Premium Income and Change in Reserve for Rate Credits** — Revenues consist of net premium income that is recognized in the period in which enrollees are entitled to receive health care services. Net premium income is shown net of reinsurance premiums paid and reinsurance premiums incurred but not paid in the financial statements.

  Comprehensive commercial health plans with MLRs on fully insured products, as calculated under the definitions in the ACA and implementing regulations, that fall below certain targets are required to rebate ratable portions of premiums annually. The Company classifies changes to the estimated rebates and retrospective premium adjustments as change in reserve for rate credits in the financial statements (see Note 24).

  Medicare plans with MLRs on fully insured products, as calculated under the definitions in the ACA and implementing regulations, that fall below certain targets are required to rebate ratable portions of premiums annually. In addition, the Company records premium adjustments for changes to the CMS Medicare Plan risk corridor program. Changes to these estimates are reflected in change in reserve for rate credits in the financial statements (see Note 24). Net premium income also includes premium under the Medicare Plan which includes CMS premiums, including amounts pursuant to the CMS risk adjustment program (see Note 24), and the CMS low-income premium subsidy for the Company's insurance risk coverage.

  The Medicaid plans are subject to experience rated rebates, including MLRs and risk corridor programs, and performance guarantees based on various utilization measures. The Company records premium adjustments for the changes to the estimates for experience rated rebates and risk corridor programs which are reflected in change in reserve for rate credits and performance guarantees which are reflected in net premium income in the financial statements (see Note 24). Net premium income also includes amounts paid by state and federal governments on a per member basis in exchange for the provision and administration of medical benefits under the Medicaid and CHIP programs, and maternity payments. Premiums are contractual and are recognized in the coverage period in which members are entitled to receive services, except in the case of maternity

payments. Maternity income is billed on contractual rates and recognized as income as each birth case is identified by the Company.

- **Total Hospital and Medical Expenses** — Total hospital and medical expenses include claims paid, claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees have received but for which claims have not yet been submitted, and payments and liabilities for physician, hospital, and other medical costs disputes.

  Total hospital and medical expenses also include amounts incurred for incentive pool, withhold adjustments, and bonus amounts that are based on the underlying contractual provisions with the respective providers. In addition, adjustments to claims unpaid estimates and aggregate health claim reserves are reflected in the period once the change in estimate is identified and included in total hospital and medical expenses in the financial statements.

- **General Administrative Expenses** — General expenses that have been paid as of the reporting date in addition to general expenses that have been incurred but are not due until a subsequent period are reported as general administrative expenses. Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to UHS in exchange for administrative and management services. Costs for items not included within the scope of the Agreement are directly expensed as incurred. State income taxes and premium taxes are also a component of GAE. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and GAE to be reported in the financial statements.

- **Federal Income Taxes Incurred** — The provision for federal income taxes incurred is calculated based on applying the statutory federal income tax rate of 21% to net income before federal income taxes and net realized capital gains (losses) subject to certain adjustments (see Note 9).

REINSURANCE

- **Reinsurance Ceded** — The Company has an insolvency-only reinsurance agreement with UnitedHealthcare Insurance Company ("UHIC"), an affiliate whereby 0.1% of net premium income is ceded to UHIC (see Note 23).

  The Company also has a reinsurance agreement through which 60% of comprehensive commercial and Medicaid earned member premiums, hospital and medical benefits, and operating expenses are ceded to UHIC (see Note 23).

- **Amounts Recoverable from Reinsurers** — The Company records amounts recoverable from the reinsurer which represents amounts contractually due to the Company as net reinsurance recoveries in the financial statements.

- **Ceded Reinsurance Premiums Payable** — The ceded reinsurance premiums payable balance represents amounts due to the reinsurer for specified coverage which will be paid based on the contract terms.

OTHER

- **Vulnerability Due to Certain Concentrations** — The Company is subject to substantial federal and state government regulation, including licensing and other requirements relating to the offering of the Company's existing products in new markets and offerings of new products, both of which may restrict the Company's ability to expand its business.

The Company has no commercial customers that individually exceed 10% of total direct premiums written and premiums and considerations, for the years ended December 31, 2021 and 2020.

Direct premiums written and premiums and considerations, including receivables for contracts subject to redetermination, from CMS related to the Medicare Plan as a percentage of total direct premiums written and premiums and considerations, including receivables for contracts subject to redetermination, are 34% and 17% as of December 31, 2021 and 27% and 5% as of December 31, 2020, respectively.

Direct premiums written and premiums and consideration, including receivables for contracts subject to redetermination, from the KDHE as a percentage of total direct premiums written and total premiums and considerations, including receivables for contracts subject to redetermination, are 44% and 50% as of December 31, 2021 and 51% and 66% as of December 31, 2020, respectively. Direct premiums written and premiums and consideration, including receivables for contracts subject to redetermination, from HealthNet as a percentage of total direct premiums written and total premiums and considerations, including receivables for contracts subject to redetermination, are 22% and 33% as of December 31, 2021 and 22% and 29% as of December 31, 2020, respectively.

Recently Issued Accounting Standards — In July 2020, the NAIC revised Statement of Statutory Accounting Principles ("SSAP") No. 106, *Affordable Care Act Section 9010 Assessment* for the repeal of the Affordable Care Act Section 9010 Assessment, effective January 1, 2021. The Company adopted the revision on the effective date.

The Company reviewed all other recently issued guidance in 2021 and 2020 that has been adopted for 2021 or subsequent years' implementation and has determined that none of the items would have a significant impact to the financial statements.

D. Going Concern

The Company has the ability and will continue to operate for a period of time sufficient to carry out its commitments, obligations and business objectives.

2. ACCOUNTING CHANGES AND CORRECTIONS OF ERRORS

No changes in accounting principles or corrections of errors have been recorded during the years ended December 31, 2021 and 2020.

3. BUSINESS COMBINATIONS AND GOODWILL

A–E. The Company was not party to a business combination during the years ended December 31, 2021 and 2020, and does not carry goodwill in its financial statements.

4. DISCONTINUED OPERATIONS

A. Discontinued Operation Disposed of or Classified as Held for Sale

(1–4) The Company did not have any discontinued operations disposed of or classified as held for sale during 2021 and 2020.

B. Change in Plan of Sale of Discontinued Operation — Not applicable.

C. Nature of any Significant Continuing Involvement with Discontinued Operations after Disposal — Not applicable.

D. Equity Interest Retained in the Discontinued Operation after Disposal — Not applicable.

5. INVESTMENTS

For purposes of calculating gross realized gains and losses on sales of investments, the amortized cost of each investment sold is used. The gross realized gains and losses on sales of long-term investments were $176,623 and $0, respectively, for 2021 and $20,513 and $19,838, respectively, for 2020. There were no gross realized gains and losses on sales of short-term investments in 2021 or 2020. The net realized gain is included in net realized capital gains (losses) less capital gains taxes. Total proceeds on the sale of long-term investments were $2,413,444 and $289,439 in 2021 and 2020, respectively. There were no proceeds on sale of short-term investments in 2021 and 2020.

As of December 31, 2021 and 2020, the book/adjusted carrying value, fair value, and gross unrecognized unrealized gains and losses of the Company's investments, excluding cash and cash equivalents of $58,053,386 and $128,480,610 respectively, are disclosed in the table below:

	2021				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 11,246,587	$ 224,616	$ 49,240	$ 7,658	$ 11,414,305
State and agency municipal securities	5,068,408	334,827	-	-	5,403,235
City and county municipal securities	8,756,204	488,489	18,121	-	9,226,572
Corporate debt securities	26,134,879	764,567	167,133	39,333	26,692,980
Total bonds	$ 51,206,078	$ 1,812,499	$ 234,494	$ 46,991	$ 52,737,092

	2021				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
Less than one year	$ 1,673,357	$ 15,286	$ -	$ -	$ 1,688,643
One to five years	14,492,707	417,490	27,496	-	14,882,701
Five to ten years	21,527,649	1,059,907	130,341	39,333	22,417,882
Over ten years	13,512,365	319,816	76,657	7,658	13,747,866
Total bonds	$ 51,206,078	$ 1,812,499	$ 234,494	$ 46,991	$ 52,737,092

	2020				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 13,209,165	$ 773,560	$ 3,691	$ -	$ 13,979,034
State and agency municipal securities	5,169,379	456,820	-	-	5,626,199
City and county municipal securities	8,913,636	627,489	-	-	9,541,125
Corporate debt securities	24,769,739	1,511,394	4,763	13,044	26,263,326
Total bonds	$ 52,061,919	$ 3,369,263	$ 8,454	$ 13,044	$ 55,409,684

Included in U.S. government and agency securities and corporate debt securities in the tables above are mortgage-related loan-backed securities, which do not have a single maturity date. For the years to maturity table above, these securities have been presented in the maturity group based on the securities' final maturity date and at a book/adjusted carrying value of $12,868,934 and fair value of $13,113,360.

The following table illustrates the fair value and gross unrecognized unrealized losses, aggregated by investment category and length of time that the individual securities have been in a continuous unrecognized unrealized loss position as of December 31, 2021 and 2020:

	2021					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 3,464,096	$ 49,240	$ 365,116	$ 7,658	$ 3,829,212	$ 56,898
City and county municipal securities	980,235	18,121	-	-	980,235	18,121
Corporate debt securities	7,783,264	167,133	628,758	39,333	8,412,022	206,466
Total bonds	$ 12,227,595	$ 234,494	$ 993,874	$ 46,991	$ 13,221,469	$ 281,485

	2020					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 877,971	$ 3,691	$ -	$ -	$ 877,971	$ 3,691
Corporate debt securities	709,265	4,763	386,956	13,044	1,096,221	17,807
Total bonds	$ 1,587,236	$ 8,454	$ 386,956	$ 13,044	$ 1,974,192	$ 21,498

The unrecognized unrealized losses on investments in U.S. government and agency securities, city and county municipal securities, and corporate debt securities at December 31, 2021 and 2020, were mainly caused by interest rate fluctuations and not by unfavorable changes in the credit ratings associated with these securities. The Company evaluates impairment at each reporting period for each of the securities whereby the fair value of the investment is less than its book/adjusted carrying value. The contractual cash flows of the U.S. government and agency securities are guaranteed either by the U.S. government or an agency of the U.S. government. It is expected that the securities would not be settled at a price less than the cost of the investment, and the Company does not intend to sell the investment until the unrealized loss is fully recovered. The Company assessed the credit quality of the city and county municipal securities and corporate debt securities, noting whether a significant deterioration since purchase or other factors that may indicate an other-than-temporary impairment ("OTTI"), such as the length of time and extent to which fair value has been less than cost, the financial condition, and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the investment. Additionally, the Company evaluated its intent and ability to retain loan-backed securities for a period of time sufficient to recover the amortized cost. As a result of these reviews, the Company recorded an OTTI of $0 and $31,392 as of December 31, 2021 and 2020, respectively, which are included in net realized capital gains (losses) less capital gains taxes.

A–C. The Company has no mortgage loans, real estate loans, restructured debt, or reverse mortgages. The Company also has no real estate property occupied by the Company, real estate property held for the production of income, or real estate property held for sale.

D. Loan-Backed Securities

(1) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the book/adjusted carrying value, commonly referred to as amortized cost, of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors.

(2) The Company did not recognize any OTTIs on loan-backed securities as of December 31, 2021 and 2020.

(3) The Company did not have any loan-backed securities with OTTIs to report by CUSIP as of December 31, 2021 or 2020.

(4) The following table illustrates the fair value, gross unrecognized unrealized losses, and length of time that the loan-backed securities have been in a continuous unrecognized unrealized loss position as of December 31, 2021 and 2020:

	2021
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 66,024
2. 12 months or longer	7,658
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	4,734,727
2. 12 months or longer	365,116

	2020
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 3,691
2. 12 months or longer	13,044
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	924,107
2. 12 months or longer	386,956

(5) The Company believes that it will continue to collect timely the principal and interest due on its loan-backed securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate changes and not by unfavorable changes in the credit quality associated with these securities that impacted the assessment on collectability of principal and interest. At each reporting period, the Company evaluates available-for-sale debt securities for any credit-related impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the expected cash flows and the underlying credit quality and credit ratings of the issuers, noting no significant credit deterioration since purchase. As of December 31, 2021, the unrealized loss on any security that the Company classified as intent to sell was not material to the Company's investment portfolio. Any other securities in an unrealized loss position as of December 31, 2021, the Company considers to be temporary.

E. **Dollar Repurchase Agreements and/or Securities Lending Transactions** — Not applicable.

F. **Repurchase Agreements Transactions Accounted for as Secured Borrowing** — Not applicable.

G. **Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing** — Not applicable.

H. **Repurchase Agreements Transactions Accounted for as a Sale** — Not applicable.

I. **Reverse Repurchase Agreements Transactions Accounted for as a Sale** — Not applicable.

J. **Real Estate** — Not applicable.

K. Low-Income Housing Tax Credits — Not applicable.

L. Restricted Assets —

(1) Restricted assets, including pledged securities as of December 31, 2021 and 2020, are presented below:

Restricted Asset Category	1 Total Gross (Admitted & Nonadmitted) Restricted From Current Year	2 Total Gross (Admitted & Nonadmitted) Restricted From Prior Year	3 Increase/ (Decrease) (1 Minus 2)	4 Total Current Year Nonadmitted Restricted	5 Total Current Year Admitted Restricted (1 minus 4)	6 Gross (Admitted & Nonadmitted) Restricted to Total Assets (a)	7 Admitted Restricted to Total Admitted Assets (b)
a. Subject to contractual obligation for which liability is not shown	$ -	$ -	$ -	$ -	$ -	- %	- %
b. Collateral held under security lending agreements	-	-	-	-	-	-	-
c. Subject to repurchase agreements	-	-	-	-	-	-	-
d. Subject to reverse repurchase agreements	-	-	-	-	-	-	-
e. Subject to dollar repurchase agreements	-	-	-	-	-	-	-
f. Subject to dollar reverse repurchase agreements	-	-	-	-	-	-	-
g. Placed under option contracts	-	-	-	-	-	-	-
h. Letter stock or securities restricted as to sale — excluding FHLB capital stock	-	-	-	-	-	-	-
i. FHLB capital stock	-	-	-	-	-	-	-
j. On deposit with states	932,749	912,943	19,806	-	932,749	<1 %	<1 %
k. On deposit with other regulatory bodies	-	-	-	-	-	-	-
l. Pledged as collateral to FHLB (including assets backing funding agreements)	-	-	-	-	-	-	-
m. Pledged as collateral not captured in other categories	-	-	-	-	-	-	-
n. Other restricted assets	-	-	-	-	-	-	-
o. Total restricted assets	$ 932,749	$ 912,943	$ 19,806	$ -	$ 932,749	- %	- %

(a) Column 1 divided by Asset Page, Column 1, Line 28
(b) Column 5 divided by Asset Page, Column 3, Line 28

(2–4) The Company has no assets pledged as collateral not captured in other categories and no other restricted assets as of December 31, 2021 or 2020.

M. Working Capital Finance Investments — Not applicable.

N. Offsetting and Netting of Assets and Liabilities

The Company does not have any offsetting or netting of assets and liabilities as it relates to derivatives, repurchase and reverse repurchase agreements, and securities borrowing and securities lending activities.

O. 5GI Securities

The Company does not have any investments with an NAIC designation of 5GI as of December 31, 2021 and 2020.

P. Short Sales — Not applicable.

Q. Prepayment Penalty and Acceleration Fees

The following table illustrates prepayment penalty and acceleration fees as of December 31, 2021:

	General Account
1. Number of CUSIPs	3
2. Aggregate Amount of Investment Income	$ 10,005

R. Reporting Entity's Share of Cash Pool by Asset Type — Not applicable.

6. JOINT VENTURES, PARTNERSHIPS, AND LIMITED LIABILITY COMPANIES

A–B. The Company has no investments in joint ventures, partnerships, or limited liability companies that exceed 10% of admitted assets and did not recognize any impairment write-down for its investments in joint ventures, partnerships, and limited liability companies during the statement periods.

7. INVESTMENT INCOME

A. The Company excludes all investment income due and accrued amounts that are over 90 days past due from the financial statements.

B. There were no investment income amounts excluded from the financial statements.

8. DERIVATIVE INSTRUMENTS

A–B. The Company has no derivative instruments.

9. INCOME TAXES

A. Deferred Tax Asset/Liability

(1) The components of the net deferred tax asset at December 31, 2021 and 2020 are as follows:

	2021			2020			Change		
	1	2	3 (Col 1+2)	4	5	6 (Col 4+5)	7 (Col 1 - 4)	8 (Col 2 - 5)	9 (Col 7+8)
	Ordinary	Capital	Total	Ordinary	Capital	Total	Ordinary	Capital	Total
(a) Gross deferred tax assets	$ 1,744,795	$ -	$ 1,744,795	$ 1,809,951	$ -	$ 1,809,951	$ (65,156)	$ -	$ (65,156)
(b) Statutory valuation allow ance adjustments	-	-	-	-	-	-	-	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	1,744,795	-	1,744,795	1,809,951	-	1,809,951	(65,156)	-	(65,156)
(d) Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	1,744,795	-	1,744,795	1,809,951	-	1,809,951	(65,156)	-	(65,156)
(f) Deferred tax liabilities	47,023	-	47,023	58,779	-	58,779	(11,756)	-	(11,756)
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	$ 1,697,772	$ -	$ 1,697,772	$ 1,751,172	$ -	$ 1,751,172	$ (53,400)	$ -	$ (53,400)

(2) The components of the adjusted gross deferred tax assets admissibility calculation under SSAP No. 101, Income Taxes, are as follows:

	2021			2020			Change		
	1	2	3	4	5	6	7	8	9
Admission Calculation Components SSAP No. 101	Ordinary	Capital	(Col 1 + 2) Total	Ordinary	Capital	(Col 4 + 5) Total	(Col 1 - 4) Ordinary	(Col 2 - 5) Capital	(Col 7 + 8) Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 1,744,795	$ -	$ 1,744,795	$ 1,809,951	$ -	$ 1,809,951	$ (65,156)	$ -	$ (65,156)
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation. (The lesser of 2(b)1 and 2(b)2 below)	-	-	-	-	-	-	-	-	-
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	-	-	-	-	-	-	-	-	-
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	45,206,203	XXX	XXX	38,201,003	XXX	XXX	7,005,200
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	-	-	-	-	-	-	-	-	-
(d) Deferred tax assets admitted as the result of application of SSAP No. 101 Total (2(a) + 2(b) + 2(c))	$ 1,744,795	$ -	$ 1,744,795	$ 1,809,951	$ -	$ 1,809,951	$ (65,156)	$ -	$ (65,156)

(3) The ratio percentage and adjusted capital and surplus used to determine the recovery period and threshold limitations for the admissibility calculation are presented below:

	2021	2020
(a) Ratio percentage used to determine recovery period and threshold limitation amount	>300%	>300%
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)(2) above	$ 301,374,685	$ 254,673,350

(4) The impact to the gross deferred tax assets balances as a result of tax-planning strategies as of December 31, 2021 and 2020 is presented below:

	2021		2020		Change	
	1	2	3	4	5	6
Impact of Tax-Planning Strategies	Ordinary	Capital	Ordinary	Capital	(Col 1 - 3) Ordinary	(Col 2 - 4) Capital
(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets by tax character as a percentage.						
1. Adjusted gross DTAs amount from Note 9A1(c)	$ 1,744,795	$ -	$ 1,809,951	$ -	$ (65,156)	$ -
2. Percentage of adjusted gross DTAs by tax character attributable to the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
3. Net admitted adjusted gross DTAs amount from Note 9A1(e)	$ 1,744,795	$ -	$ 1,809,951	$ -	$ (65,156)	$ -
4. Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
(b) Does the Company's tax-planning strategies include the use of reinsurance?			Yes		No X	

B. Unrecognized Deferred Tax Liabilities

(1–4) There are no unrecognized deferred tax liabilities for the years ended December 31, 2021 and 2020.

C. Significant Components of Income Taxes

(1) The current federal income taxes incurred for the years ended December 31, 2021 and 2020 are as follows:

	1 2021	2 2020	3 (Col 1 - 2) Change
1. Current income tax			
(a) Federal	$ 34,874,994	$ 34,356,191	$ 518,803
(b) Foreign	-	-	-
(c) Subtotal	34,874,994	34,356,191	518,803
(d) Federal income tax on net capital gains (losses)	37,111	(6,451)	43,562
(e) Utilization of capital loss carryforwards	-	-	-
(f) Other	-	-	-
(g) Total federal and foreign income taxes incurred	$ 34,912,105	$ 34,349,740	$ 562,365

(2–4) The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities as of December 31, 2021 and 2020, are as follows:

	1 2021	2 2020	3 (Col 1 - 2) Change
2. Deferred tax assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$ 269,508	$ 409,316	$ (139,808)
(2) Unearned premium reserve	5	17	(12)
(3) Policyholder reserves	397	-	397
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	-	-	-
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables — nonadmitted	1,474,885	1,400,618	74,267
(11) Net operating loss carryforward	-	-	-
(12) Tax credit carryforward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	-	-	-
(99) Subtotal	1,744,795	1,809,951	(65,156)
(b) Statutory valuation allowance adjustment	-	-	-
(c) Nonadmitted	-	-	-
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	1,744,795	1,809,951	(65,156)
(e) Capital:			
(1) Investments	-	-	-
(2) Net capital loss carryforward	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	-	-	-
(99) Subtotal	-	-	-
(f) Statutory valuation allowance adjustment	-	-	-
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	-	-	-
(i) Admitted deferred tax assets (2d + 2h)	1,744,795	1,809,951	(65,156)
3. Deferred tax liabilities:			
(a) Ordinary:			
(1) Investments	-	-	-
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	47,023	58,779	(11,756)
(99) Subtotal	47,023	58,779	(11,756)
(b) Capital:			
(1) Investments	-	-	-
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	-	-	-
(99) Subtotal	-	-	-
(c) Deferred tax liabilities (3a99 + 3b99)	47,023	58,779	(11,756)
4. Net deferred tax assets/liabilities (2i - 3c)	$ 1,697,772	$ 1,751,172	$ (53,400)

The other ordinary deferred tax liability of $47,023 and $58,779 for 2021 and 2020, respectively consists of discounting unpaid losses.

The Company assessed the potential realization of the gross deferred tax asset and as a result no statutory valuation allowance was required and no allowance was established as of December 31, 2021 and 2020.

D. The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate of 21% to net income before federal income taxes incurred, plus capital gains tax (benefit). A summarization of the significant items causing this difference as of December 31, 2021 and 2020 is as follows:

	2021		2020	
	Amount	Effective Tax Rate	Amount	Effective Tax Rate
Tax provision at the federal statutory rate	$ 35,062,964	21 %	$ 27,157,817	21 %
Tax-exempt interest	(51,454)	-	(52,424)	-
Health insurer fee	-	-	7,259,148	6
Other current year items	28,137	-	165,106	-
Tax effect of nonadmitted assets	(74,142)	-	508,888	-
Total statutory income taxes	$ 34,965,505	21 %	$ 35,038,535	27 %
Federal income taxes incurred	$ 34,874,994	21 %	$ 34,356,191	26 %
Capital gains tax (benefit)	37,111	-	(6,451)	-
Change in net deferred income tax	53,400	-	688,795	1
Total statutory income taxes	$ 34,965,505	21 %	$ 35,038,535	27 %

E. At December 31, 2021, the Company had no net operating loss carryforwards.

Current federal income taxes (payable) recoverable of ($2,287,104) and $1,594,260 as of December 31, 2021 and 2020, respectively, are included in the financial statements. Federal income taxes paid, net of refunds, were $31,030,741 and $41,865,188 in 2021 and 2020, respectively.

Federal income taxes incurred of $34,912,105 and $34,349,740 for 2021 and 2020, respectively, are available for recoupment in the event of future net losses.

The Company has not admitted any aggregate amounts of deposits that are included within Section 6603 (“Deposits made to suspend running of interest on potential underpayments, etc.”) of the Internal Revenue Service (“IRS”) Code.

F. The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group. The entities included within the consolidated return are included in the NAIC Statutory Statement Schedule Y — Information Concerning Activities of Insurer Members Of A Holding Company Group. Federal income taxes are paid to or refunded by UnitedHealth Group pursuant to the terms of a tax-sharing agreement, approved by the Board of Directors, under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal return of UnitedHealth Group. UnitedHealth Group currently files income tax returns in the U.S. federal jurisdiction, various states, and foreign jurisdictions. The U.S. IRS has completed exams on

UnitedHealth Group's consolidated income tax returns for fiscal years 2016 and prior. UnitedHealth Group's 2017 through 2020 tax returns are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, UnitedHealth Group is no longer subject to income tax examinations prior to the 2014 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2015 and forward. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

G. Tax Contingencies — Not applicable.

H. Repatriation Transition Tax — Not applicable.

I. Alternative Minimum Tax Credit — Not applicable.

10. INFORMATION CONCERNING PARENT, SUBSIDIARIES, AND AFFILIATES

A–B. In the ordinary course of business, the Company contracts with several affiliates to provide a wide variety of services to the Company's members. These agreements are filed with and approved by the Department according to Management's understanding of the current requirements and standards. Within the confines of the applicable filed and approved agreements (including subsequent amendments thereto), the amount and types of services provided by these affiliated entities can change year over year.

The Company has a tax-sharing agreement with UnitedHealth Group (see Note 9).

The Company paid dividends of $85,000,000 and $43,200,000 in 2021 and 2020, respectively, to its parent (see Note 13).

The Company holds a $40,000,000 subordinated revolving credit agreement with UnitedHealth Group at an interest rate of London InterBank Offered Rate plus a margin of 0.50%. This credit agreement is subordinate to the extent it does not conflict with any credit facility held by either party. The credit agreement is effective as of the effective date and shall continue until terminated pursuant to the terms of this agreement which requires either party to give a 60 day written notice to the other party. No amounts were outstanding under the line of credit as of December 31, 2021 and 2020. No amount of interest was paid or still accrued on all borrowings throughout the years of December 31, 2021 and 2020, respectively.

The Company has entered into reinsurance agreements with an affiliated entity (see Note 23).

C. Transactions With Related Parties Who Are Not Reported On Schedule Y

The Company has no material related party transactions that meet the disclosure requirements pursuant to SSAP No. 25, *Affiliates and Other Related Parties* ("SSAP No. 25") that are not included in NAIC Statutory Statement Schedule Y — Part 2 Summary Of Insurer's Transactions With Any Affiliates.

D. At December 31, 2021 and 2020, the Company reported $16,647,481 and $18,178,607, respectively, as amounts due to parent, subsidiaries, and affiliates, which are included in the financial statements. These balances are generally settled within 90 days from the incurred date. Any balances due to the Company that are not settled within 90 days are considered nonadmitted assets.

E. The administrative services, access fees, and cost of care services provided by affiliates are calculated using one or more of the following methods: (1) a percentage of premiums; (2) use of assets; (3) direct pass-through of charges; (4) per member per month ; (5) per employee per

month; (6) per claim; or (7) a combination thereof consistent with the provisions contained in each contract. These amounts are included in GAE, CAE, and hospital and medical expenses in the financial statements. The following table identifies the amounts reported for the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2021 and 2020, which meet the disclosure requirements pursuant to SSAP No. 25, regardless of the effective date of the contract:

	2021	2020
LifePrint Health, Inc.	$ 707,068,219	$ -
OptumRx	237,853,921	221,538,303
UHS	200,440,695	193,499,220
United Behavioral Health	179,330,658	148,615,379
naviHealth, Inc.	6,596,222	-
OptumInsight, Inc.	6,046,049	9,486,917
Dental Benefit Providers, Inc.	4,774,360	3,915,415

LifePrint Health, Inc. provides services that may include, but are not limited to, care management services to eligible members and/or arranging for the delivery of clinical services to the Company's enrollees.

OptumRx provides services that may include, but are not limited to, administrative services related to pharmacy management and pharmacy claims processing for enrollees, manufacturer rebate administration, pharmacy incentive services, specialty drug pharmacy services, durable medical equipment services including orthotics and prosthetics and personal health products catalogues showing the healthcare products and benefit credits enrollees needed to redeem the respective products.

UHS provides, or arranges for the provision of, management, administrative, and other services deemed necessary or appropriate for UHS to provide management and operational support to the Company. The services can include, but are not limited to, the categories of management and operational services outlined in the Agreement, such as human resources, legal, facilities, general administration, treasury and investment functions, claims adjudication and payment, benefit administration, disease management, health care decision support, medical management, credentialing, preventative health services, utilization management reporting and expenses incurred for new business that will be effective in the subsequent year.

United Behavioral Health provides services related to mental health and substance abuse treatment.

naviHealth, Inc. provides comprehensive post-acute services and care delivery.Dental Benefit Providers, Inc. provides dental care assistance.

The Company has premium payments that are received and claim payments that are processed and paid by an affiliated UnitedHealth Group entity. Premiums and claims applicable to the Company are settled at regular intervals throughout the month via the intercompany settlement process and any amounts outstanding are reflected in payable amounts due to parent, subsidiaries, and affiliates, in the financial statements.

The Company's affiliate, UHS, provides a guarantee to the KDHE to perform the Company's obligations and discharge its liabilities under the Medicaid contract should the Company fail to perform. The parent will also indemnify and hold harmless the KDHE against any and all losses, damages, claims, costs, charges, and expenses under the terms of the contract.

F. The Company has not extended any guarantees or undertakings for the benefit of an affiliate or related party.

G. The Company is part of an insurance holding company system with UnitedHealth Group as the ultimate parent. Management believes that the Company's transactions with affiliates are fair and reasonable; however, operations of the Company may not be indicative of those that would have occurred if it had operated as an independent company.

H. The Company does not have any amount deducted from the value of an upstream intermediate entity or ultimate parent owned, either directly or indirectly, via a downstream subsidiary, controlled, or affiliated entity.

I. The Company does not have any investments in a subsidiary, controlled, or affiliated entity that exceeds 10% of admitted assets.

J. The Company does not have any investments in impaired subsidiaries, controlled, or affiliated entities.

K. The Company does not have any investments in foreign insurance subsidiaries.

L. The Company does not hold any investments in a downstream noninsurance holding company.

M. The Company does not have any investments in noninsurance subsidiaries, controlled, or affiliated entities.

N. The Company does not have any investments in insurance subsidiaries, controlled, or affiliated entities.

O. The Company does not have any investments in subsidiary, controlled, or affiliated entities or joint ventures, partnerships and limited liability companies in which the Company's share of losses exceeds the investment.

11. DEBT

A–B. The Company had no outstanding debt with third-parties or outstanding Federal Home Loan Bank agreements during 2021 and 2020.

12. RETIREMENT PLANS, DEFERRED COMPENSATION, POSTEMPLOYMENT BENEFITS AND COMPENSATED ABSENCES AND OTHER POSTRETIREMENT BENEFIT PLANS

A–I. The Company has no defined benefit plans, defined contribution plans, multiemployer plans, consolidated/holding company plans, postemployment benefits, or compensated absences plans and is not impacted by the Medicare Modernization Act on postretirement benefits, since all personnel are employees of UHS, which provides services to the Company under the terms of the Agreement (see Note 10).

13. CAPITAL AND SURPLUS, DIVIDEND RESTRICTIONS, AND QUASI-REORGANIZATIONS

A–B. The Company has 100 shares authorized and 1 share issued and outstanding of $1 par value common stock. The Company has no preferred stock outstanding. All issued and outstanding shares of common stock are held by the Company's parent, UHC.

C. Dividend payment requirements are outlined in the domiciliary state statutes and may be further restricted by the Department.

D. The Company paid extraordinary cash dividends of $50,000,000 and $35,000,000 on September 20, 2021 and December 17, 2021, respectively, to UHC, which were approved by the Department and recorded as a reduction to unassigned surplus in the financial statements.

The Company paid an ordinary cash dividend to UHC of $3,200,000 on June 5, 2020, which required no approval and was recorded as a reduction to unassigned surplus in the financial statements. The Company paid extraordinary cash dividends to UHC of $20,000,000 on September 21, 2020 and December 21, 2020, which were approved by the Department and recorded as a reduction to unassigned surplus in the financial statements.

E. The amount of ordinary dividends that may be paid out during any given period is subject to certain restrictions as specified by state statute.

F. There are no restrictions placed on the Company's unassigned surplus.

G. The Company is not a mutual reciprocal or a similarly organized entity and does not have advances to surplus not repaid.

H. The Company does not hold any stock, including stock of affiliated companies for special purposes, such as conversion of preferred stock, employee stock options, or stock purchase warrants.

I. The Company does not have any special surplus funds.

J. The portion of unassigned surplus, excluding net income and dividends, represented (or reduced) by each item below is as follows:

	2021	2020
Net deferred income taxes	$ 1,697,772	$ 1,751,172
Nonadmitted assets	(7,023,261)	(6,670,203)
Total	$ (5,325,489)	$ (4,919,031)

K–M. The Company does not have any outstanding surplus notes and has never been a party to a quasi-reorganization.

14. LIABILITIES, CONTINGENCIES AND ASSESSMENTS

A. Contingent Commitments

The Company has no contingent commitments.

B. Assessments

The Company is not aware of any guaranty fund assessments or premium tax offsets, potential or accrued, that could have a material financial effect on the operations of the entity.

C. Gain Contingencies

The Company is not aware of any gain contingencies that should be disclosed in the financial statements.

D. Claims Related Extra Contractual Obligation and Bad Faith Losses Stemming from Lawsuits — Not applicable.

E. Joint and Several Liabilities — Not applicable.

F. All Other Contingencies

The Company's business is regulated at the federal, state, and local levels. The laws and rules governing the Company's business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Further, the Company must obtain and maintain regulatory approvals to market and sell many of its products.

The Company has been, or is currently involved, in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments and other governmental authorities. The Company cannot reasonably estimate the range of loss, if any, that may result from any material government investigations, audits and reviews in which it is currently involved given the inherent difficulty in predicting regulatory action, fines and penalties, if any, and the various remedies and levels of judicial review available to the Company in the event of an adverse finding.

On February 14, 2017, the Department of Justice ("DOJ") announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges that the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, the DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters involve: indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility, or it is probable that a loss may be incurred. Although the outcomes of any such legal actions cannot be predicted, in the opinion of management, the resolution of any currently pending or threatened actions will not have a material adverse effect on the financial statements of the Company.

The Company routinely evaluates the collectability of all receivable amounts included in the financial statements. Impairment reserves are established for those amounts where collectability is uncertain. Based on the Company's past experience, exposure related to uncollectible balances and the potential of loss for those balances not currently reserved for is not material to the Company's statutory basis financial condition.

There are no assets that the Company considers to be impaired at December 31, 2021 and 2020, except as disclosed in Note 5.

15. LEASES

A–B. According to the Agreement between the Company and UHS (see Note 10), operating leases for the rental of office facilities and equipment are the responsibility of UHS. Fees associated with the lease agreements are included as a component of the Company's management fee.

16. INFORMATION ABOUT FINANCIAL INSTRUMENTS WITH OFF-BALANCE-SHEET RISK AND FINANCIAL INSTRUMENTS WITH CONCENTRATIONS OF CREDIT RISK

(1–4) The Company does not hold any financial instruments with off-balance-sheet risk or have any concentrations of credit risk.

17. SALE, TRANSFER, AND SERVICING OF FINANCIAL ASSETS AND EXTINGUISHMENTS OF LIABILITIES

A–C. The Company did not participate in any transfer of receivables, financial assets or wash sales.

18. GAIN OR LOSS TO THE REPORTING ENTITY FROM UNINSURED PLANS AND THE UNINSURED PORTION OF PARTIALLY INSURED PLANS

A–B. The Company has no operations from Administrative Services Only Contracts or Administrative Services Contracts in 2021 and 2020.

C. Medicare or Other Similarly Structured Cost Based Reimbursement Contract

The Medicare Part D program is a partially insured plan. The Company recorded a receivable of $39,644,087 and $19,412,230 at December 31, 2021 and 2020, respectively, for cost reimbursement under the Medicare Part D program for the catastrophic reinsurance and low-income member cost-sharing subsidies. The Company also recorded a receivable of $28,299 and $1,954 at December 31, 2021 and 2020, respectively, for the Medicare Part D coverage gap discount program. The receivables are recorded in amounts receivable relating to uninsured plans in the financial statements. These Medicare subsidies are described in Note 1, *Amounts Receivable Relating to Uninsured Plans.*

The Company participates in administering the payments for the HealthNet's Federal Reimbursement Allowance ("FRA") program. There is no risk to the Company as a result of these transactions. The Company has a FRA program payable of $1,149,255 and $1,767,624 as of December 31, 2021 and 2020, respectively, which is included in liability for amounts held under uninsured plans in the financial statements.

19. DIRECT PREMIUM WRITTEN/PRODUCED BY MANAGING GENERAL AGENTS/THIRD-PARTY ADMINISTRATORS

The Company did not have any direct premiums written or produced by managing general agents or third-party administrators in 2021 and 2020.

20. FAIR VALUE MEASUREMENTS

The NAIC SAP defines fair value, establishes a framework for measuring fair value, and outlines the disclosure requirements related to fair value measurements. The fair value hierarchy is as follows:

Level 1 — Quoted (unadjusted) prices for identical assets in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets in active markets;
- Quoted prices for identical or similar assets in nonactive markets (few transactions, limited information, noncurrent prices, high variability over time, etc.);
- Inputs other than quoted prices that are observable for the asset (interest rates, yield curves, volatilities, default rates, etc.);
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

The estimated fair values of bonds and cash equivalents based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service ("pricing service"), which generally uses quoted prices or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, non-binding broker quotes, benchmark yields, credit spreads, default rates, and prepayment speeds. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to a secondary pricing source, prices reported by its custodian, its investment consultant, and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and review of fair value methodology documentation provided by independent pricing services have not historically resulted in an adjustment in the prices obtained from the pricing service.

In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement has been determined based on the lowest-level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

A. Fair Value

(1) Fair Value Measurements at Reporting Date

The following tables present information about the Company's financial assets that are measured and reported at fair value at December 31, 2021 and 2020, in the financial statements according to the valuation techniques the Company used to determine their fair values:

	December 31, 2021				
Description for Each Class of Asset or Liability	**(Level 1)**	**(Level 2)**	**(Level 3)**	**Net Asset Value (NAV)**	**Total**
a. Assets at fair value:					
Perpetual preferred stock:					
Industrial and misc	$ -	$ -	$ -	$ -	$ -
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total perpetual preferred stocks	-	-	-	-	-
Bonds:					
U.S. governments	-	-	-	-	-
Industrial and misc	-	-	-	-	-
Hybrid securities	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total bonds	-	-	-	-	-
Common stock:					
Industrial and misc	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stocks	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forw ard contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	57,799,537	-	-	-	57,799,537
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 57,799,537	$ -	$ -	$ -	$ 57,799,537
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

Description for Each Class of Asset or Liability	December 31, 2020 (Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Total
a. Assets at fair value:					
Perpetual preferred stock:					
Industrial and misc	$ -	$ -	$ -	$ -	$ -
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total perpetual preferred stocks	-	-	-	-	-
Bonds:					
U.S. governments	-	-	-	-	-
Industrial and misc	-	-	-	-	-
Hybrid securities	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total bonds	-	-	-	-	-
Common stock:					
Industrial and misc	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stocks	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forward contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	128,441,832	-	-	-	128,441,832
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 128,441,832	$ -	$ -	$ -	$ 128,441,832
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

(2) The Company does not have any financial assets with a fair value hierarchy of Level 3 that were measured and reported at fair value.

(3) Transfers between fair value hierarchy levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs. There were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during the years ended December 31, 2021 or 2020.

(4) The Company has no investments reported with a fair value hierarchy of Level 2 or Level 3 and therefore has no valuation technique to disclose.

(5) The Company has no derivative assets and liabilities to disclose.

B. Fair Value Combination — Not applicable.

C. Aggregate Fair Value Hierarchy

The aggregate fair value by hierarchy of all financial instruments as of December 31, 2021 and 2020 is presented in the table below:

	December 31, 2021						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 11,414,305	$ 11,246,587	$ 3,060,572	$ 8,353,733	$ -	$ -	$ -
State and agency municipal securities	5,403,235	5,068,408	-	5,403,235	-	-	-
City and county municipal securities	9,226,572	8,756,204	-	9,226,572	-	-	-
Corporate debt securities	26,692,980	26,134,879	-	26,692,980	-	-	-
Cash equivalents	57,799,537	57,799,537	57,799,537	-	-	-	-
Total bonds and cash equivalents	$ 110,536,629	$ 109,005,615	$ 60,860,109	$ 49,676,520	$ -	$ -	$ -

	December 31, 2020						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 13,979,034	$ 13,209,165	$ 5,073,985	$ 8,905,049	$ -	$ -	$ -
State and agency municipal securities	5,626,199	5,169,379	-	5,626,199	-	-	-
City and county municipal securities	9,541,125	8,913,636	-	9,541,125	-	-	-
Corporate debt securities	26,263,326	24,769,739	-	26,263,326	-	-	-
Cash equivalents	128,441,832	128,441,832	128,441,832	-	-	-	-
Total bonds and cash equivalents	$ 183,851,516	$ 180,503,751	$ 133,515,817	$ 50,335,699	$ -	$ -	$ -

D. Not Practicable to Estimate Fair Value — Not applicable.

E. Investments Measured Using the NAV Practical Expedient — Not applicable.

21. OTHER ITEMS

COVID-19 Trends and Uncertainties

The COVID-19 pandemic continues to evolve and the ultimate overall impact to the Company's financial statements is uncertain and dependent on the future pacing, intensity and duration of the pandemic, the severity of new variants of the COVID-19 virus, the effectiveness and extent of administration of vaccination and treatments and general economic uncertainty.

Throughout 2020, the Company's ultimate parent announced a number of programs to directly support people affected by the COVID-19 pandemic, including a plan to grant premium credits to the Company's fully insured commercial customers. The total amount of premium credits granted through December 31, 2020 of $97 has been reflected as a reduction to net premium income in the financial statements.

A. Unusual or Infrequent Items

The Company did not encounter any unusual or infrequent items for the years ended December 31, 2021 and 2020.

B. Troubled Debt Restructuring: Debtors

The Company has no troubled debt restructurings as of December 31, 2021 and 2020.

C. Other Disclosures

The Company does not have any amounts not recorded in the financial statements that represent segregated funds held for others. The Company also does not have any exposures related to forward commitments that are not derivative instruments.

D. Business Interruption Insurance Recoveries

The Company has not received any business interruption insurance recoveries during 2021 and 2020.

E. State Transferable and Non-transferable Tax Credits

The Company has no transferable or non-transferable state tax credits.

F. Sub-Prime Mortgage-Related Risk Exposure

(1) The investment policy for the Company limits investments in loan-backed securities, which includes sub-prime issuers. Further, the policy limits investments in private-issuer mortgage securities to 10% of the portfolio, which also includes sub-prime issuers. The exposure to unrealized losses on sub-prime issuers is due to changes in market prices. There are no realized losses due to not receiving anticipated cash flows. The investments covered have an NAIC designation of 1 or 2.

(2) The Company has no direct exposure through investments in sub-prime mortgage loans.

(3) The Company has no direct exposure through other investments.

(4) The Company has no underwriting exposure to sub-prime mortgage risk through mortgage guaranty or financial guaranty insurance coverage.

G. Retained Assets

The Company does not have any retained asset accounts for beneficiaries.

H. Insurance-Linked Securities Contracts

As of December 31, 2021, the Company is not aware of any possible proceeds of insurance-linked securities.

I. The Amount That Could Be Realized on Life Insurance Where the Reporting Entity is Owner and Beneficiary or Has Otherwise Obtained Rights to Control the Policy — Not applicable.

22. EVENTS SUBSEQUENT

Subsequent events have been evaluated through April 21, 2022, which is the date these financial statements were available for issuance.

TYPE I — Recognized Subsequent Events

Any material Type I events subsequent to December 31, 2021, have been recognized in the financial statements and corresponding disclosures.

TYPE II — Non-Recognized Subsequent Events

There are no material non-recognized Type II events that require disclosure.

23. REINSURANCE

Reinsurance Agreements — In the normal course of business, the Company seeks to reduce potential losses that may arise from catastrophic events that cause unfavorable underwriting results by reinsuring certain levels of such risk with an affiliated reinsurer. The Company remains primarily liable as the direct insurer on all risks reinsured.

The Company has a reinsurance agreement with UHIC, an affiliate of the Company, through which 60% of earned comprehensive commercial and Medicaid member premiums, hospital and medical expenses, and operating expenses are transferred to UHIC. The Company transferred premiums of $1,351,518,927 and $1,238,838,278, and GAE and CAE of $145,514,774 and $152,282,578 in 2021 and 2020, respectively, to UHIC under this agreement. The Company recorded receivables related to changes in reserve estimates of $87,209,268 and $85,628,940 in 2021 and 2020, respectively, which are netted against claims unpaid and aggregate health claim reserves in the financial statements. The Company recorded reinsurance receivables of $10,188,947 and $8,262,278 in 2021 and 2020, respectively, related to the KDHE risk corridor reserves, which are netted against aggregate health policy reserves in the financial statements. The Company recognized reinsurance recoveries of $1,087,369,469 and $994,673,161 in 2021 and 2020, respectively, which are recorded as net reinsurance recoveries in the financial statements. The Company recorded ceded reserves for provider incentives of $2,469,980 and $1,750,058 in 2021 and 2020, respectively, which are included in accrued medical incentive pool and bonus amounts in the financial statements. The Company recorded paid claims receivables related to this agreement, including payments made for the MLR rebates of $92,826,846 and $89,645,722 in 2021 and 2020, respectively, which are included in amounts recoverable from reinsurers in the financial statements. The Company recorded a receivable related to GAE and CAE of $15,885,403 and $15,418,689 in 2021 and 2020, respectively, which are included in other amounts receivable under reinsurance contracts in the financial statements. The Company recorded a payable to UHIC for premiums ceded of $126,680,582 and $106,736,460 as of December 31, 2021 and 2020, respectively, which are included in ceded reinsurance premiums payable in the financial statements. The agreement also provides insolvency-only protection for its enrollees. Fees related to this agreement, which are calculated based on a percentage of earned premiums, of $3,397,000 and $2,810,638 in 2021 and 2020, respectively, are netted against net premium income in the financial statements. The Company recorded a payable to UHIC for premiums ceded related to the insolvency agreement of $316,377 and $218,941 in 2021 and 2020, respectively, which are included in ceded reinsurance premiums payable in the financial statements. This agreement also provides for reserve cap protection. Reinsurance contracts do not relieve the Company from its obligations to policyholders. Failure of reinsurers to honor their obligations could result in losses to the Company.

The effect of both internal and external reinsurance agreements outlined above on net premium income, hospital and medical expenses, GAE, and CAE is presented below:

	2021	2020
Premiums:		
Direct	$ 3,400,693,198	$ 2,816,853,893
Ceded:		
Affiliate	1,354,915,927	1,241,648,916
Net premium income	$ 2,045,777,271	$ 1,575,204,977
Change in reserve for rate credits:		
Direct	$ (2,191,920)	$ (10,443,076)
Ceded:		
Affiliate	1,926,669	8,262,278
Net change in reserve for rate credits	$ (265,251)	$ (2,180,798)
Hospital and medical expenses:		
Direct	$ 2,775,335,353	$ 2,244,465,494
Ceded:		
Affiliate	1,087,369,469	994,673,161
Net hospital and medical expenses	$ 1,687,965,884	$ 1,249,792,333
General administrative expenses and claims adjustment expenses:		
Direct	$ 337,380,893	$ 347,857,433
Ceded:		
Affiliate	145,514,774	152,282,578
Net general administrative expenses and claims adjustment expenses	$ 191,866,119	$ 195,574,855

A. Ceded Reinsurance Report

Section 1 — General Interrogatories

(1) Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes ( ) No (X)

(2) Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor, or any other person not primarily engaged in the insurance business?

Yes ( ) No (X)

Section 2 — Ceded Reinsurance Report — Part A

(1) Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credit?

Yes ( ) No (X)

(2) Does the reporting entity have any reinsurance agreements in effect that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

Yes ( ) No (X)

Section 3 — Ceded Reinsurance Report — Part B

(1) What is the estimated amount of the aggregate reduction in surplus (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of all reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

The Company estimates there should be no aggregate reduction in surplus for termination of all reinsurance agreements as of December 31, 2021.

(2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes ( ) No (X)

B. **Uncollectible Reinsurance** — During 2021 and 2020, there were no uncollectible reinsurance recoverables.

C. **Commutation of Ceded Reinsurance** — There was no commutation of reinsurance in 2021 or 2020.

D. **Certified Reinsurer Rating Downgraded or Status Subject to Revocation** — Not applicable.

E. **Reinsurance Credit**

(1) The Company has no ceding reinsurance contracts subject to Appendix A-791 — *Life and Health Reinsurance Agreements* (“A-791”) that includes a provision which limits the reinsurer’s assumption of significant risk.

(2) The Company has no ceding reinsurance contracts not subject to A-791, for which reinsurance accounting was applied and which include a provision that limits the reinsurer’s assumption of risk.

(3) The Company’s reinsurance contracts do not contain features which result in delays in payment in form or in fact.

(4) The Company has not reflected a reinsurance accounting credit for any assumption reinsurance contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk transfer requirements of SSAP No. 61R, *Life, Deposit-Type, and Accident and Health Reinsurance* ("SSAP No. 61R").

(5) The Company did not cede any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract during the period covered by these financial statements, for which the statutory accounting treatment and GAAP accounting treatment were not the same.

(6) The Company's ceded reinsurance contract which are not subject to A-791 and not yearly renewable term reinsurance, is treated the same for GAAP and statutory accounting principles.

24. RETROSPECTIVELY RATED CONTRACTS AND CONTRACTS SUBJECT TO REDETERMINATION

A. The Company estimates accrued retrospective premium adjustments for its group health insurance business based on mathematical calculations in accordance with contractual terms.

B. Estimated accrued retrospective premiums due to (from) the Company are recorded in premiums and considerations and aggregate health policy reserves in the financial statements and as an adjustment to change in reserve for rate credits in the financial statements.

C. Pursuant to the ACA, the Company's commercial and Medicare business is subject to retrospectively rated features based on the actual MLR experienced on the commercial and Medicare lines of business and redetermination features for premium adjustments for changes to each member's health scores based on guidelines determined by the ACA. The total amount of direct premiums written for the commercial and Medicare lines of business for which a portion is subject to the retrospectively rated and redetermination features was $23,149 and $394,779, and $1,148,395,679 and $755,982,588, representing less than 1%, and 34% and 27% of total direct premiums written as of December 31, 2021 and 2020, respectively.

The Company has Medicare Part D risk-corridor amounts from CMS which are subject to a retrospectively rated feature. The Company has estimated accrued retrospective premiums related to certain Part D premiums based on guidelines determined by CMS. The formula is tiered and based on the bid MLR. The amount of Medicare Part D direct premiums written subject to the retrospectively rated feature was $57,205,131 and $33,607,887, representing 2% and 1% of total direct premiums written as of December 31, 2021 and 2020, respectively.

The Company's KanCare program is subject to retrospectively rated features based on the actual MLR experiences on the Medicaid line of business. The formula is calculated pursuant to the terms outlined in the KanCare contract. The total amount of direct premiums written from the Medicaid contract for which a portion is subject to the retrospectively rated features was $1,487,482,246 and $1,429,463,408, representing 44% and 51% of total direct premiums written as of December 31, 2021 and 2020, respectively.

The KanCare contract, including CHIP, with the State of Kansas includes a provision for which a stated percentage of total direct premiums written can be eligible for a performance guarantee payment, based on various quality measures. The total amount of direct premiums written from the Medicaid contract, including CHIP, for which a portion is subject to the redetermination feature was $45,110,004 and $42,931,490, representing 1% and 2%, of total direct premiums written as of December 31, 2021 and 2020, respectively.

The Company's HealthNet Program is subject to retrospectively rated features based on actual MLR experiences on the Medicaid line of business. The formula is calculated pursuant to the

terms outlined in the HealthNet contract. The total amount of direct premiums written from the Medicaid contract for which a portion is subject to the retrospectively rated feature was $764,792,124 and $631,013,118, representing 22% of total direct premiums written as of December 31, 2021 and 2020, respectively.

The HealthNet contract, including CHIP, with the State of Missouri includes a provision for which a stated percentage of total direct premiums written can be eligible for a performance guarantee payment, based on various quality measures. The total amount of direct premiums written from the Medicaid contract, including CHIP, for which a portion is subject to the redetermination feature was $20,336,434 and $16,300,510, representing 1% of total direct premiums written as of December 31, 2021 and 2020, respectively.

Effective January 1, 2020 for the 2020 contract year, KDHE implemented a risk corridor program into the Company's KDHE Medicaid and CHIP contract. The Company has estimated accrued retrospective premiums based on guidelines determined by the KDHE. The formula is tiered and based on a targeted MLR based on guidelines determined by the KDHE. The formula is tiered and based on a baseline benefit expense. The total amount of direct premiums written for the KDHE Medicaid and CHIP business for which a portion is subject to the retrospectively rated feature was $1,411,114,698, representing 50% of total direct premiums written as of December 31, 2020.

D. The Company is required to maintain specific minimum loss ratios on the comprehensive commercial and Medicare lines of business.

The following table discloses the minimum MLR rebate liability for the Medicare line of business which is included in aggregate health policy reserves in the financial statements for the years ended December 31, 2021 and 2020:

	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Other Categories with Rebates	5 Total
Prior reporting year					
(1) Medical loss ratio rebates incurred	$ -	$ -	$ -	$ 6,091,505	$ 6,091,505
(2) Medical loss ratio rebates paid	-	-	-	6,870,288	6,870,288
(3) Medical loss rebates unpaid	-	-	-	8,332,915	8,332,915
(4) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(5) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(6) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	8,332,915
Current reporting year-to-date					
(7) Medical loss ratio rebates incurred	-	-	-	(1,132,746)	(1,132,746)
(8) Medical loss ratio rebates paid	-	-	-	2,912,507	2,912,507
(9) Medical loss rebates unpaid	-	-	-	4,287,662	4,287,662
(10) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(11) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(12) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	4,287,662

Pursuant to the Medicaid Managed Care Rule, based on the State's election and state contractual minimum loss ratio requirements, the Company is required to maintain specific MLRs on its HealthNet and KanCare populations. The Company has estimated $3,956,881 and $0 in estimated Medicaid Managed Care Rule and state MLR rebates on its HealthNet population as of December 31, 2021 and 2020, respectively, which is included in aggregate health policy reserves. The Company's actual MLR for the Medicaid Managed Care Rule and state contractual requirements for the KanCare population were in excess of the minimum requirements and as a result, no MLR liability was required as of December 31, 2021 and 2020, respectively.

E. Risk-Sharing Provisions of the Affordable Care Act

(1) The Company has accident and health insurance premiums in 2021 and 2020 subject to the risk-sharing provisions of the ACA.

The ACA imposed fees and premium stabilization provisions on health insurance issuers offering comprehensive commercial health insurance. The three premium stabilization programs are commonly referred to as the 3Rs — risk adjustment, reinsurance, and risk corridors.

Risk Adjustment — The risk adjustment program is a permanent program designed to mitigate the potential impact of adverse selection that generally applies to non-grandfathered individual and small group plans inside and outside of exchanges. The program helps to stabilize market premiums by transferring funds from plans with relatively low-risk enrollees to plans with relatively high-risk enrollees. The data used by CMS to determine the risk adjustment transfer amount is subject to audits along with the true-up to the final CMS report, which may result in a material change to arrive at the final risk adjustment amount from the initial risk adjustment estimate recorded. Premium adjustments pursuant to the risk adjustment program are accounted for as premium subject to redetermination and user fees are accounted for as assessments.

Reinsurance and Risk Corridors — The transitional reinsurance program and risk corridors program were temporary programs which expired at the end of 2016. The Company received $272,954 in 2020 from CMS for the settlement of the temporary ACA risk corridor program which has been reflected in net premium income in the financial statements. The details of the years impacted and the amounts received are included in Note 24E 4 and Note 24E 5 below.

(2) The Company has accident and health insurance premiums in 2021 and 2020 subject to the ACA risk-sharing provisions but has no balances as indicated in the table below, due to immateriality of the amounts.

		December 31, 2021
a.	**Permanent ACA Risk Adjustment Program**	
	Assets	
1.	Premium adjustments receivable due to ACA Risk Adjustment (including high-risk pool payments)	$ -
	Liabilities	
2.	Risk adjustment user fees payable for ACA Risk Adjustment	-
3.	Premium adjustments payable due to ACA Risk Adjustment (including high-risk pool premium)	-
	Operations (Revenue & Expense)	
4.	Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment	-
5.	Reported in expenses as ACA Risk Adjustment user fees (incurred/paid)	-
b.	**Transitional ACA Reinsurance Program**	
	Assets	
1.	Amounts recoverable for claims paid due to ACA Reinsurance	$ -
2.	Amounts recoverable for claims unpaid due to ACA Reinsurance (Contra Liability)	-
3.	Amounts receivable relating to uninsured plans for contributions for ACA Reinsurance	-
	Liabilities	
4.	Liabilities for contributions payable due to ACA Reinsurance - not reported as ceded premium	-
5.	Ceded reinsurance premiums payable due to ACA Reinsurance	-
6.	Liabilities for amounts held under uninsured plans contributions for ACA Reinsurance	-
	Operations (Revenue & Expense)	
7.	Ceded reinsurance premiums due to ACA Reinsurance	-
8.	Reinsurance recoveries (income statement) due to ACA reinsurance payments or expected payments	-
9.	ACA Reinsurance contributions - not reported as ceded premium	-
c.	**Temporary ACA Risk Corridors Program**	
	Assets	
1.	Accrued retrospective premium due to ACA Risk Corridors	$ -
	Liabilities	
2.	Reserve for rate credits or policy experience rating refunds due to ACA Risk Corridors	-
	Operations (Revenue & Expense)	
3.	Effect of ACA Risk Corridors on net premium income (paid/received)	-
4.	Effect of ACA Risk Corridors on change in reserves for rate credits	-

(3) The following table is a rollforward of the prior year ACA risk-sharing provisions for asset and liability balances, along with reasons for adjustments to prior year balances:

	Accrued during the Prior Year on Business Written before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 - 3)	Prior Year Accrued Less Payments (Col 2 - 4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1 - 3 + 7)	Cumulative Balance from Prior Years (Col 2 - 4 + 8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustment receivable (including high-risk pool payments)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	A	$ -	$ -
2. Premium adjustment (payable) (including high-risk pool premium)	-	-	-	-	-	-	-	-	B	-	-
3. Subtotal ACA Permanent Risk Adjustment Program	-	-	-	-	-	-	-	-		-	-
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	-	-	-	-	-	-	-	-	C	-	-
2. Amounts recoverable for claims unpaid (contra liability)	-	-	-	-	-	-	-	-	D	-	-
3. Amounts receivable relating to uninsured plans	-	-	-	-	-	-	-	-	E	-	-
4. Liabilities for contributions payable due to ACA Reinsurance — not reported as ceded premium	-	-	-	-	-	-	-	-	F	-	-
5. Ceded reinsurance premiums payable	-	-	-	-	-	-	-	-	G	-	-
6. Liability for amounts held under uninsured plans	-	-	-	-	-	-	-	-	H	-	-
7. Subtotal ACA Transitional Reinsurance Program	-	-	-	-	-	-	-	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	I	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	J	-	-
3. Subtotal ACA Risk Corridors Program	-	-	-	-	-	-	-	-		-	-
d. Total for ACA Risk-Sharing Provisions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -

Explanation of Adjustments

A. N/A
B. N/A
C. N/A
D. N/A
E. N/A
F. N/A
G. N/A
H. N/A
I. N/A
J. N/A

(4) The Company does not have any risk corridor receivables or payables to present in the table below.

	Accrued during the Prior Year on Business Written before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 - 3)	Prior Year Accrued Less Payments (Col 2 - 4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1 - 3 + 7)	Cumulative Balance from Prior Years (Col 2 - 4 + 8)
	1	2	3	4	5	6	7	8		9	10
Risk Corridors Program Year	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. 2014											
1. Accrued retrospective premium	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	A	$ -	$ -
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	B	-	-
b. 2015											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	C	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	D	-	-
c. 2016											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	E	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	F	-	-
d. Total for Risk Corridors	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -

Explanation of Adjustments

A. N/A
B. N/A
C. N/A
D. N/A
E. N/A
F. N/A

(5) The following table discloses ACA risk corridor receivable balances by risk corridor program year:

Risk Corridors Program Year	1 Estimated Amount to be Filed or Final Amount Filed with CMS	2 Non-Accrued Amounts for Impairment or Other Reasons	3 Amounts Received from CMS	4 Asset Balance (Gross of Non-Admissions) (1 - 2 - 3)	5 Non-Admitted Amount	6 Net Admitted Asset (4 - 5)
a. 2014	$ -	$ -	$ -	$ -	$ -	$ -
b. 2015	115,915	-	115,915	-	-	-
c. 2016	157,039	-	157,039	-	-	-
d. Total (a + b + c)	$ 272,954	$ -	$ 272,954	$ -	$ -	$ -

25. CHANGE IN INCURRED CLAIMS AND CLAIMS ADJUSTMENT EXPENSES

A. Changes in estimates related to the prior year incurred claims are included in total hospital and medical expenses in the current year in the financial statements. The following tables disclose paid claims, incurred claims, and the balance in claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, health care receivables (excluding provider loans and advances not yet expensed) and reinsurance recoverables for the years ended December 31, 2021 and 2020:

	2021		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (126,190,104)	$ (126,190,104)
Paid claims — net of health care receivables* and reinsurance recoveries collected	1,770,346,237	(20,290,542)	1,750,055,695
End of year claim reserve	84,312,118	4,919,183	89,231,301
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	1,854,658,355	(141,561,463)	1,713,096,892
Beginning of year health care receivables* and reinsurance recoverables	-	133,373,693	133,373,693
End of year health care receivables* and reinsurance recoverables	(155,695,451)	(2,789,250)	(158,484,701)
Total incurred claims	$ 1,698,962,904	$ (10,977,020)	$ 1,687,985,884

*Health care receivables excludes provider loans and advances not yet expensed of $15,000 and $30,000 for 2021 and 2020, respectively.

	2020		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (111,292,955)	$ (111,292,955)
Paid claims — net of health care receivables* and reinsurance recoveries collected	1,267,094,753	(1,523,660)	1,265,571,093
End of year claim reserve	121,272,136	4,917,968	126,190,104
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	1,388,366,889	(107,898,647)	1,280,468,242
Beginning of year health care receivables* and reinsurance recoverables	-	102,697,784	102,697,784
End of year health care receivables* and reinsurance recoverables	(129,702,795)	(3,670,898)	(133,373,693)
Total incurred claims	$ 1,258,664,094	$ (8,871,761)	$ 1,249,792,333

*Health care receivables excludes provider loans and advances not yet expensed of $30,000 and $60,000 for 2020 and 2019, respectively.

The liability for claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, net of health care receivables (excluding provider loans and advances not yet expensed), and reinsurance recoverables as of December 31, 2020 was ($7,183,589). As of December 31, 2021, ($20,290,542) has been paid for incurred claims attributable to insured events of prior years. Reserves remaining for prior years, net of health care receivables (excluding provider loans and advances not yet expensed) and reinsurance recoverables are now $2,129,933, as a result of re-estimation of unpaid claims. Therefore, there has been $10,977,020 favorable prior year development since December 31, 2020 to December 31, 2021. The primary drivers consist of favorable development of $19,489,299 in retroactivity for inpatient, outpatient, physician, and pharmacy claims and favorable development as a result of a change in the provision for adverse deviations in experience of $7,921,925, offset by $7,924,461 unfavorable development in reinsurance, unfavorable development of $7,356,836 in capitation, and $2,366,604 unfavorable development in accruals for other miscellaneous benefits. At December 31, 2020, the Company recorded $8,871,761 of favorable development. The primary drivers consist of favorable development as a result of a change in the provision for adverse deviations in experience of $7,283,663 and favorable development of $6,876,828 in retroactivity for inpatient, outpatient, physician, and pharmacy claims, offset by unfavorable development of $3,445,759 in capitation, and unfavorable development of $1,146,240 in provider settlements. Original estimates are increased or decreased as additional information becomes known regarding individual claims, which could have an impact to the accruals for MLR rebates and retrospectively rated contracts. As a result of the prior year effects, on a regular basis, the Company adjusts revenue and the corresponding liability and/or receivable related to retrospectively rated policies and the impact of the change is included as a component of change in reserve for rate credits in the financial statements.

The Company incurred CAE of $60,864,494 and $70,100,168 in 2021 and 2020, respectively. These costs are included in the management service fees paid by the Company to UHS as a part of the Agreement (see Note 10). The following table discloses paid CAE, incurred CAE, and the balance in unpaid CAE reserve for 2021 and 2020:

	2021	2020
Total claims adjustment expenses	$ 60,864,494	$ 70,100,168
Less: current year unpaid claims adjustment expenses	(2,431,339)	(2,329,097)
Add: prior year unpaid claims adjustment expenses	2,329,097	2,048,408
Total claims adjustment expenses paid	$ 60,762,252	$ 69,819,479

B. The Company did not make any significant changes in methodologies and assumptions used in the calculation of the liability for claims unpaid and unpaid CAE in 2021.

26. INTERCOMPANY POOLING ARRANGEMENTS

A–G. The Company did not have any intercompany pooling arrangements in 2021 or 2020.

27. STRUCTURED SETTLEMENTS

A–B. The Company did not have structured settlements in 2021 or 2020.

28. HEALTH CARE RECEIVABLES

A. Pharmacy rebates receivable are recorded when reasonably estimated or billed by the affiliated pharmaceutical benefit manager in accordance with pharmaceutical rebate contract provisions. Information used to support rebates billed to the manufacturer is based on utilization information gathered by the pharmaceutical benefit manager and adjusted for significant changes in pharmaceutical contract provisions.

The Company evaluates admissibility of all pharmacy rebates receivable based on the administration of each underlying pharmaceutical benefit management agreement. The Company has nonadmitted and excluded all pharmacy rebates receivable that do not meet the admissibility criteria of SSAP No. 84, *Health Care and Government Insured Plan Receivables* (“SSAP No. 84”) from the financial statements.

For each pharmaceutical management agreement for which a portion of the total pharmacy rebates receivable can be admitted based on the admissibility criteria of SSAP No. 84, the pharmacy rebate transaction history is summarized as follows:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received within 90 Days of Billing	Actual Rebates Received within 91 to 180 Days of Billing	Actual Rebates Received More than 180 Days after Billing
12/31/2021	$ 42,636,269	$ 13,536,123	$ -	$ -	$ -
9/30/2021	40,510,277	41,169,727	25,439,118	-	-
6/30/2021	38,429,030	38,737,383	32,499,623	4,325,388	-
3/31/2021	33,653,574	33,901,622	26,333,295	5,322,680	576,085
12/31/2020	27,553,139	26,722,318	22,680,823	3,829,519	99,140
9/30/2020	25,441,589	25,035,892	21,035,935	3,433,730	370,752
6/30/2020	24,816,024	24,046,909	20,419,835	3,361,768	316,652
3/31/2020	22,708,365	21,760,036	8,879,536	12,990,064	15,054
12/31/2019	18,192,106	18,870,874	14,615,042	2,943,819	980,118
9/30/2019	18,462,735	18,790,929	14,403,484	3,166,016	846,728
6/30/2019	18,227,557	18,584,255	13,556,511	4,443,243	287,539
3/31/2019	15,683,107	16,223,128	12,984,210	2,133,898	809,826

Of the amount reported as health care receivables, $57,554,032 and $36,966,331 relates to pharmacy rebates receivable as of December 31, 2021 and 2020, respectively. This change is primarily due to increased membership along with the change in generic/name brand mix.

B. The Company has nonadmitted all risk-sharing receivables from the financial statements.

The Company also admitted $135,528 and $144,749 of provider receivables resulting from claim overpayments, and $984,919 and $0 for capitation arrangement receivables as of December 31, 2021 and 2020, respectively, which are included in health care receivables in the financial statements.

29. PARTICIPATING POLICIES

The Company did not have any participating contracts in 2021 or 2020.

30. PREMIUM DEFICIENCY RESERVES

The following table summarizes the Company's PDR as of December 31, 2021 and 2020:

	2021	
1. Liability carried for premium deficiency reserves	$	1,889
2. Date of the most recent evaluation of this liability		12/31/2021
3. Was anticipated investment income utilized in this calculation?	Yes [X]	No [ ]

	2020	
1. Liability carried for premium deficiency reserves	$	-
2. Date of the most recent evaluation of this liability		12/31/2020
3. Was anticipated investment income utilized in this calculation?	Yes [X]	No [ ]

PDR is included in aggregate health policy reserves in the financial statements.

31. ANTICIPATED SALVAGE AND SUBROGATION

Due to the type of business being written, the Company has no salvage. As of December 31, 2021 and 2020, the Company had no specific accruals established for outstanding subrogation, as it is considered a component of the actuarial calculations used to develop the estimates of claims unpaid and aggregate health claim reserves.

* * * * * *

SUPPLEMENTAL SCHEDULES

EXHIBIT I:
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2021
(To Be Filed by April 1)

Of The UnitedHealthcare of the Midwest, Inc.

ADDRESS (City, State and Zip Code) Minnetonka , MN 55343

NAIC Group Code 0707 NAIC Company Code 96385 Federal Employer's Identification Number (FEIN) 43-1361841

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 591,706,039

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	DEUTSCHE GOV - ICAXX	Cash Equivalents	$ 11,200,691	1.9 %
2.02	Invesco AIM - AGPXX	Cash Equivalents	$ 9,633,888	1.6 %
2.03	Goldman Sachs - FGTXX	Cash Equivalents	$ 6,991,130	1.2 %
2.04	FNMA	Bonds	$ 5,183,197	0.9 %
2.05	Northern Inst - BGSXX	Cash Equivalents	$ 4,441,147	0.8 %
2.06	FHLMC	Bonds	$ 3,045,945	0.5 %
2.07	JP Morgan - OGVXX	Cash Equivalents	$ 1,681,858	0.3 %
2.08	EDISON INTL	Bonds	$ 918,225	0.2 %
2.09	JPMORGAN CHASE	Bonds	$ 870,000	0.1 %
2.10	REGL TRANSPRTN A - TRAN	Bonds	$ 861,577	0.1 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 42,788,867	7.2 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 8,417,210	1.4 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 0	0.0 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 0	0.0 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 0	0.0 %	3.11	P/RP-5	$ 0	0.0 %
3.06	NAIC-6	$ 0	0.0 %	3.12	P/RP-6	$ 0	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 0	0.0 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

SUPPLEMENT FOR THE YEAR 2021 OF THE UnitedHealthcare of the Midwest, Inc.

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 0	0.0 %
5.02	Countries designated NAIC-2	$ 0	0.0 %
5.03	Countries designated NAIC-3 or below	$ 0	0.0 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1:	$ 0	0.0 %
6.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
6.03	Country 1:	$ 0	0.0 %
6.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1:	$ 0	0.0 %
6.06	Country 2:	$ 0	0.0 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$ 0	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$ 0	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1:	$ 0	0.0 %
9.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$ 0	0.0 %
9.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$ 0	0.0 %
9.06	Country 2:	$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01			$ 0	0.0 %
10.02			$ 0	0.0 %
10.03			$ 0	0.0 %
10.04			$ 0	0.0 %
10.05			$ 0	0.0 %
10.06			$ 0	0.0 %
10.07			$ 0	0.0 %
10.08			$ 0	0.0 %
10.09			$ 0	0.0 %
10.10			$ 0	0.0 %

SUPPLEMENT FOR THE YEAR 2021 OF THE UnitedHealthcare of the Midwest, Inc.

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 0	0.0 %
11.03	Canadian-currency-denominated investments	$ 0	0.0 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.0 %
11.05	Unhedged Canadian currency exposure	$ 0	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$ 0	0.0 %
12.04		$ 0	0.0 %
12.05		$ 0	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	0.0 %

SUPPLEMENT FOR THE YEAR 2021 OF THE UnitedHealthcare of the Midwest, Inc.

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for 14.02 through 14.05.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.0 %
14.04		$ 0	0.0 %
14.05		$ 0	0.0 %

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06		$ 0	$ 0	$ 0
14.07		$ 0	$ 0	$ 0
14.08		$ 0	$ 0	$ 0
14.09		$ 0	$ 0	$ 0
14.10		$ 0	$ 0	$ 0
14.11		$ 0	$ 0	$ 0
14.12		$ 0	$ 0	$ 0
14.13		$ 0	$ 0	$ 0
14.14		$ 0	$ 0	$ 0
14.15		$ 0	$ 0	$ 0

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.0 %
	Largest three investments in general partnership interests:		
15.03		$ 0	0.0 %
15.04		$ 0	0.0 %
15.05		$ 0	0.0 %

SUPPLEMENT FOR THE YEAR 2021 OF THE UnitedHealthcare of the Midwest, Inc.

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ 0	0.0 %
16.03		$ 0	0.0 %
16.04		$ 0	0.0 %
16.05		$ 0	0.0 %
16.06		$ 0	0.0 %
16.07		$ 0	0.0 %
16.08		$ 0	0.0 %
16.09		$ 0	0.0 %
16.10		$ 0	0.0 %
16.11		$ 0	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.0 %
16.15	Mortgage loans foreclosed	$ 0	0.0 %
16.16	Restructured mortgage loans	$ 0	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential		Commercial		Agricultural	
	Loan to Value	1	2	3	4	5	6
17.01	above 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.02	91 to 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.03	81 to 90%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.04	71 to 80%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.05	below 70%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ 0	0.0 %
18.03		$ 0	0.0 %
18.04		$ 0	0.0 %
18.05		$ 0	0.0 %
18.06		$ 0	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$ 0	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.0 %
19.04		$ 0	0.0 %
19.05		$ 0	0.0 %

SUPPLEMENT FOR THE YEAR 2021 OF THE UnitedHealthcare of the Midwest, Inc.

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.0 %	$ 0	$ 0	$ 0
20.02	Repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 0	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ 0	0.0 %
21.03	Other	$ 0	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

EXHIBIT II:
SUMMARY INVESTMENT SCHEDULE

ANNUAL STATEMENT FOR THE YEAR 2021 OF THE UnitedHealthcare of the Midwest, Inc.

SUMMARY INVESTMENT SCHEDULE

	Investment Categories	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
		1	2	3	4	5	6
		Amount	Percentage of Column 1 Line 13	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage of Column 5 Line 13
1.	Long-Term Bonds (Schedule D, Part 1):						
	1.01 U.S. governments	3,017,445	2.762	3,017,445	0	3,017,445	2.762
	1.02 All other governments	299,830	0.274	299,830	0	299,830	0.274
	1.03 U.S. states, territories and possessions, etc. guaranteed	1,523,269	1.394	1,523,269	0	1,523,269	1.394
	1.04 U.S. political subdivisions of states, territories, and possessions, guaranteed	2,522,296	2.309	2,522,296	0	2,522,296	2.309
	1.05 U.S. special revenue and special assessment obligations, etc. non-guaranteed	18,008,187	16.482	18,008,187	0	18,008,187	16.482
	1.06 Industrial and miscellaneous	25,835,051	23.646	25,835,051	0	25,835,051	23.646
	1.07 Hybrid securities	0	0.000	0	0	0	0.000
	1.08 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	1.09 SVO identified funds	0	0.000	0	0	0	0.000
	1.10 Unaffiliated Bank loans	0	0.000	0	0	0	0.000
	1.11 Total long-term bonds	51,206,078	46.866	51,206,078	0	51,206,078	46.866
2.	Preferred stocks (Schedule D, Part 2, Section 1):						
	2.01 Industrial and miscellaneous (Unaffiliated)	0	0.000	0	0	0	0.000
	2.02 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	2.03 Total preferred stocks	0	0.000	0	0	0	0.000
3.	Common stocks (Schedule D, Part 2, Section 2):						
	3.01 Industrial and miscellaneous Publicly traded (Unaffiliated)	0	0.000	0	0	0	0.000
	3.02 Industrial and miscellaneous Other (Unaffiliated)	0	0.000	0	0	0	0.000
	3.03 Parent, subsidiaries and affiliates Publicly traded	0	0.000	0	0	0	0.000
	3.04 Parent, subsidiaries and affiliates Other	0	0.000	0	0	0	0.000
	3.05 Mutual funds	0	0.000	0	0	0	0.000
	3.06 Unit investment trusts	0	0.000	0	0	0	0.000
	3.07 Closed-end funds	0	0.000	0	0	0	0.000
	3.08 Total common stocks	0	0.000	0	0	0	0.000
4.	Mortgage loans (Schedule B):						
	4.01 Farm mortgages	0	0.000	0	0	0	0.000
	4.02 Residential mortgages	0	0.000	0	0	0	0.000
	4.03 Commercial mortgages	0	0.000	0	0	0	0.000
	4.04 Mezzanine real estate loans	0	0.000	0	0	0	0.000
	4.05 Total valuation allowance	0	0.000	0	0	0	0.000
	4.06 Total mortgage loans	0	0.000	0	0	0	0.000
5.	Real estate (Schedule A):						
	5.01 Properties occupied by company	0	0.000	0	0	0	0.000
	5.02 Properties held for production of income	0	0.000	0	0	0	0.000
	5.03 Properties held for sale	0	0.000	0	0	0	0.000
	5.04 Total real estate	0	0.000	0	0	0	0.000
6.	Cash, cash equivalents and short-term investments:						
	6.01 Cash (Schedule E, Part 1)	253,849	0.232	253,849	0	253,849	0.232
	6.02 Cash equivalents (Schedule E, Part 2)	57,799,537	52.901	57,799,537	0	57,799,537	52.901
	6.03 Short-term investments (Schedule DA)	0	0.000	0	0	0	0.000
	6.04 Total cash, cash equivalents and short-term investments	58,053,386	53.134	58,053,386	0	58,053,386	53.134
7.	Contract loans	0	0.000	0	0	0	0.000
8.	Derivatives (Schedule DB)	0	0.000	0	0	0	0.000
9.	Other invested assets (Schedule BA)	0	0.000	0	0	0	0.000
10.	Receivables for securities	0	0.000	0	0	0	0.000
11.	Securities Lending (Schedule DL, Part 1)	0	0.000	0	XXX	XXX	XXX
12.	Other invested assets (Page 2, Line 11)	0	0.000	0	0	0	0.000
13.	Total invested assets	109,259,464	100.000	109,259,464	0	109,259,464	100.000

OTHER ATTACHMENT

Deloitte.

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To the Audit Committee of
UnitedHealthcare of the Midwest, Inc.
13655 Riverport Drive, MO050-1000
Maryland Heights, MO 63043

The Management of
UnitedHealthcare of the Midwest, Inc.
13655 Riverport Drive, MO050-1000
Maryland Heights, MO 63043

Dear Members of the Audit Committee and Management:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the statutory basis financial statements of UnitedHealthcare of the Midwest, Inc. (the "Company") for the years ended December 31, 2021, and 2020, and have issued our report thereon dated April 21, 2022. In connection therewith, we advise you as follows:

1. We are independent certified public accountants with respect to the Company and conform to the standards of the accounting profession as contained in the *Code of Professional Conduct* and pronouncements of the American Institute of Certified Public Accountants, the rules and regulations of the Missouri Department of Insurance, and the Rules of Professional Conduct of the Florida Board of Accountancy.

2. The engagement partner and engagement manager, who are certified public accountants, have 22 years and 8 years, respectively, of experience in public accounting and are experienced in auditing insurance enterprises. Members of the engagement team, most of whom have had experience in auditing insurance enterprises and 28 percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

3. We understand that the Company intends to file its audited statutory basis financial statements and our report thereon with the Missouri Department of Insurance and other state insurance departments in states in which the Company is licensed and that the insurance commissioners of those states will be relying on that information in monitoring and regulating the statutory basis financial condition of the Company.

   While we understand that an objective of issuing a report on the statutory basis financial statements is to satisfy regulatory requirements, our audit was not planned to satisfy all objectives or responsibilities of insurance regulators. In this context, the Company and insurance commissioners should understand that the objective of an audit of statutory basis financial statements in accordance with auditing standards generally accepted in the United States of America is to form an opinion and issue a report on whether the statutory basis financial statements present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus, results of operations and cash flows in accordance with accounting practices prescribed or permitted by the Missouri Department of Insurance. Consequently, under auditing standards generally accepted in the United States of America, we have the responsibility, within the inherent limitations of the auditing process, to plan and perform our audit to obtain reasonable assurance regarding whether the statutory basis

financial statements are free from material misstatement, whether due to error or fraud, and to exercise due professional care in the conduct of the audit. The Company is not required to have, nor were we engaged to perform, an audit of internal control over financial reporting. Our audit included consideration of internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control over financial reporting. The concept of selective testing of the data being audited, which involves judgment both as to the number of transactions to be audited and the areas to be tested, has been generally accepted as a valid and sufficient basis for an auditor to express an opinion on financial statements. Audit procedures that are effective for detecting errors, if they exist, may be ineffective for detecting misstatements resulting from fraud. Because of the characteristics of fraud, particularly those involving concealment and falsified documentation (including forgery), a properly planned and performed audit may not detect a material misstatement resulting from fraud. In addition, an audit does not address the possibility that material misstatements may occur in the future. Also, our use of professional judgment and the assessment of materiality for the purpose of our audit mean that matters may exist that would have been assessed differently by insurance commissioners.

It is the responsibility of the management of the Company to adopt sound accounting policies, to maintain an adequate and effective system of accounts, and to establish and maintain internal control that will, among other things, provide reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition and that transactions are executed in accordance with management's authorization and are recorded properly to permit the preparation of financial statements in conformity with accounting practices prescribed or permitted by the Missouri Department of Insurance.

The Insurance Commissioner should exercise due diligence to obtain whatever other information that may be necessary for the purpose of monitoring and regulating the statutory basis financial position of insurers and should not rely solely on the independent auditor's report.

4. We will retain the working papers (including those kept in a hard copy or electronic medium) prepared in the conduct of our audit until the Missouri Department of Insurance has filed a Report of Examination covering 2021, but no longer than seven years. After notification to the Company, we will make the working papers available for review by the Missouri Department of Insurance or its delegates, at the offices of the insurer, at our offices, at the Missouri Department of Insurance, or at any other reasonable place designated by the Insurance Commissioner. Furthermore, in the conduct of the aforementioned periodic review by the Missouri Department of Insurance, photocopies of pertinent audit working papers may be made (under the control of Deloitte & Touche LLP) and such copies may be retained by the Missouri Department of Insurance. In addition, to the extent requested, we may provide the Missouri Department of Insurance with copies of certain audit working papers (such as unlocked copies of Excel spreadsheets that do not contain password protection or encryption). As such, these audit working papers will be subject to potential modification by Missouri Department of Insurance or by others. We are not responsible for any modifications made to the copies, electronic or otherwise, after they are provided to the Missouri Department of Insurance; and we are likewise not responsible for any effect that any such modifications, whether intentional or not, might have on the process, substance, or outcome of your regulatory examination.

5. The engagement partner has served in this capacity with respect to the Company since 2019, is licensed by the Florida Board of Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

6. To the best of our knowledge and belief, we are in compliance with the requirements of section 7 of the *NAIC's Model Rule (Regulation) Requiring Annual Audited Financial Reports* regarding qualifications of independent certified public accountants.

This letter is intended solely for the information and use of the Audit Committee and management of UnitedHealthcare of the Midwest, Inc. and for filing with the Missouri Department of Insurance and other state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte & Touche LLP

April 21, 2022

UnitedHealthcare of the Midwest, Inc. – 2020

Audited Financial Statements

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UnitedHealthcare of the Midwest, Inc.

Statutory Basis Financial Statements as of and for the Years Ended December 31, 2020 and 2019, Supplemental Schedules as of and for the Year Ended December 31, 2020, Independent Auditors' Report and Qualification Letter

UNITEDHEALTHCARE OF THE MIDWEST, INC.

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INDEPENDENT AUDITORS' REPORT

To the Audit Committee of
UnitedHealthcare of the Midwest, Inc.
13655 Riverport Drive, MO050-1000
Maryland Heights, MO 63043

We have audited the accompanying statutory basis financial statements of UnitedHealthcare of the Midwest, Inc. (the "Company"), which comprise the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2020 and 2019, and the related statutory basis statements of operations, changes in capital and surplus, and cash flows for the years then ended, and the related notes to the statutory basis financial statements.

Management's Responsibility for the Statutory Basis Financial Statements

Management is responsible for the preparation and fair presentation of these statutory basis financial statements in accordance with the accounting practices prescribed or permitted by the Missouri Department of Insurance. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these statutory basis financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the statutory basis financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the statutory basis financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the statutory basis financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the statutory basis financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the statutory basis financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the statutory basis financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus of UnitedHealthcare of the Midwest, Inc. as of December 31, 2020 and 2019, and the results of its operations and its cash flows for the years then ended in accordance with the accounting practices prescribed or permitted by the Missouri Department of Insurance described in Note 1 to the statutory basis financial statements.

Basis of Accounting

We draw attention to Note 1 of the statutory basis financial statements, which describes the basis of accounting. As described in Note 1 to the statutory basis financial statements, the statutory basis financial statements are prepared by UnitedHealthcare of the Midwest, Inc. using accounting practices prescribed or permitted by the Missouri Department of Insurance, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to meet the requirements of the Missouri Department of Insurance. Our opinion is not modified with respect to this matter.

Report on Supplemental Schedules

Our 2020 audit was conducted for the purpose of forming an opinion on the 2020 statutory basis financial statements as a whole. The supplemental schedules of supplemental investment risks interrogatories, summary investment schedule, and supplemental schedule regarding reinsurance contracts with risk-limiting features as of and for the year ended December 31, 2020 are presented for purposes of additional analysis and are not a required part of the 2020 statutory basis financial statements. These schedules are the responsibility of the Company's management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory basis financial statements. Such schedules have been subjected to the auditing procedures applied in our audit of the 2020 statutory basis financial statements and certain additional procedures, including comparing and reconciling such schedules directly to the underlying accounting and other records used to prepare the statutory basis financial statements or to the statutory basis financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such schedules are fairly stated in all material respects in relation to the 2020 statutory basis financial statements as a whole.

Restriction on Use

Our report is intended solely for the information and use of the Audit Committee and the management of UnitedHealthcare of the Midwest, Inc. and for filing with state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte & Touche LLP

April 23, 2021

UNITEDHEALTHCARE OF THE MIDWEST, INC.

STATUTORY BASIS STATEMENTS OF ADMITTED ASSETS, LIABILITIES, AND CAPITAL AND SURPLUS AS OF DECEMBER 31, 2020 AND 2019

	2020	2019
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$ 52,061,919	$ 50,919,769
Cash of $38,778 and $35,846 and cash equivalents of $128,441,832 and $68,865,650, in 2020 and 2019, respectively	128,480,610	68,901,496
Subtotal cash and invested assets	180,542,529	119,821,265
OTHER ASSETS:		
Investment income due and accrued	398,125	539,467
Premiums and considerations	222,628,945	186,765,793
Amounts recoverable from reinsurers	89,645,722	68,152,757
Other amounts receivable under reinsurance contracts	15,418,689	14,405,462
Amounts receivable relating to uninsured plans	19,414,184	40,899,882
Current federal income tax recoverable	1,594,260	-
Net deferred tax asset	1,751,172	2,439,967
Receivables from parent, subsidiaries, and affiliates, net	-	1,005,834
Health care receivables	37,111,080	25,532,254
Subtotal other assets	387,962,177	339,741,416
TOTAL ADMITTED ASSETS	$ 568,504,706	$ 459,562,681
LIABILITIES AND CAPITAL AND SURPLUS		
LIABILITIES:		
Claims unpaid	$ 120,307,812	$ 107,356,691
Accrued medical incentive pool and bonus amounts	4,782,607	2,956,892
Unpaid claims adjustment expenses	2,329,097	2,048,408
Aggregate health policy reserves, including $8,332,915 and $9,111,698 for medical loss ratio rebate per the Public Health Service Act for 2020 and 2019, respectively	41,617,550	30,654,326
Aggregate health claim reserves	1,099,685	979,372
Premiums received in advance	400	10,886
General expenses due or accrued	15,034,054	13,748,270
Current federal income tax payable	-	5,921,188
Ceded reinsurance premiums payable	106,955,401	91,683,885
Remittances and items not allocated	4,134	4,084
Amounts due to parent, subsidiaries, and affiliates, net	18,178,607	-
Liability for amounts held under uninsured plans	1,767,624	1,273,924
Other liabilities	3,213	7,920
Total liabilities	312,080,184	256,645,846
CAPITAL AND SURPLUS:		
Section 9010 ACA subsequent fee year assessment	-	34,403,481
Common capital stock, $1 par value — 100 shares authorized; 1 share issued and outstanding	1	1
Gross paid-in and contributed surplus	32,788,535	32,788,535
Unassigned surplus	223,635,986	135,724,818
Total capital and surplus	256,424,522	202,916,835
TOTAL LIABILITIES AND CAPITAL AND SURPLUS	$ 568,504,706	$ 459,562,681

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDWEST, INC.

STATUTORY BASIS STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2020 AND 2019

	2020	2019
REVENUES:		
Net premium income	$ 1,575,204,977	$ 1,239,913,435
Change in reserve for rate credits	(2,180,798)	(7,530,986)
Total revenues	1,573,024,179	1,232,382,449
UNDERWRITING DEDUCTIONS:		
Hospital and medical:		
Hospital/medical benefits	1,997,638,320	1,782,238,012
Other professional services	66,306,784	74,806,161
Prescription drugs	168,700,457	147,817,939
Incentive pool, withhold adjustments, and bonus amounts	11,819,933	3,237,332
Net reinsurance recoveries	(994,673,161)	(963,636,480)
Total hospital and medical	1,249,792,333	1,044,462,964
Claims adjustment expenses	70,100,168	52,258,619
General administrative expenses	125,474,687	91,973,638
(Decrease) increase in reserves for accident and health contracts	(1,151,000)	1,149,111
Total underwriting deductions	1,444,216,188	1,189,844,332
NET UNDERWRITING GAIN	128,807,991	42,538,117
NET INVESTMENT GAINS:		
Net investment income earned	1,842,243	3,269,264
Net realized capital (losses) gains less capital gains tax (benefit) expense of $(6,451) and $70,581 in 2020 and 2019, respectively	(24,267)	269,012
Total net investment gains	1,817,976	3,538,276
NET (LOSS) GAIN FROM PREMIUM BALANCES CHARGED OFF	(510,353)	15,256
OTHER LOSSES	(786,219)	(3,508,603)
NET INCOME BEFORE FEDERAL INCOME TAXES	129,329,395	42,583,046
FEDERAL INCOME TAXES INCURRED	34,356,191	9,925,607
NET INCOME	$ 94,973,204	$ 32,657,439

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDWEST, INC.

STATUTORY BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2020 AND 2019

	Section 9010 ACA Subsequent Fee Year Assessment	Common Capital Stock Shares	Common Capital Stock Amount	Gross Paid-In and Contributed Surplus	Unassigned Surplus	Total Capital and Surplus
BALANCE — January 1, 2019	$ -	1	$ 1	$ 32,788,535	$ 157,524,773	$ 190,313,309
Net income	-	-	-	-	32,657,439	32,657,439
Dividend paid	-	-	-	-	(25,000,000)	(25,000,000)
Change in net unrealized capital losses on investments less capital gains benefit of $5,044	-	-	-	-	(18,975)	(18,975)
Section 9010 ACA subsequent fee year assessment	34,403,481	-	-	-	(34,403,481)	-
Change in nonadmitted assets	-	-	-	-	5,822,455	5,822,455
Change in net deferred income taxes	-	-	-	-	(857,393)	(857,393)
BALANCE — December 31, 2019	34,403,481	1	1	32,788,535	135,724,818	202,916,835
Net income	-	-	-	-	94,973,204	94,973,204
Dividends paid	-	-	-	-	(43,200,000)	(43,200,000)
Section 9010 ACA subsequent fee year assessment	(34,403,481)	-	-	-	34,403,481	-
Change in nonadmitted assets	-	-	-	-	2,423,278	2,423,278
Change in net deferred income taxes	-	-	-	-	(688,795)	(688,795)
BALANCE — December 31, 2020	$ -	1	$ 1	$ 32,788,535	$ 223,635,986	$ 256,424,522

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDWEST, INC.

STATUTORY BASIS STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2020 AND 2019

	2020	2019
CASH FLOWS FROM OPERATIONS:		
Premiums collected, net of reinsurance	$ 1,564,536,907	$ 1,295,984,471
Net investment income	2,388,670	3,693,931
Benefit and loss related payments	(1,265,571,093)	(1,015,058,984)
Commissions and other expenses paid	(174,336,565)	(166,543,654)
Federal income taxes paid, net	(41,865,188)	(7,360,276)
Net cash provided by operations	85,152,731	110,715,488
CASH FLOWS FROM INVESTMENTS:		
Proceeds from investments:		
Bonds sold or matured	7,991,352	32,992,678
Net gains on cash equivalents and short-term investments	-	13
Total investment proceeds	7,991,352	32,992,691
Cost of investments acquired:		
Bonds	(9,574,751)	(11,215,610)
Other applications	-	(2,348,149)
Total cost of investments acquired	(9,574,751)	(13,563,759)
Net cash (used in) provided by investments	(1,583,399)	19,428,932
CASH FLOWS FROM FINANCING AND MISCELLANEOUS ACTIVITIES:		
Cash provided through (used in) net transfers from (to) affiliates	19,184,441	(44,244,838)
Dividends paid	(43,200,000)	(25,000,000)
Other cash provided	25,341	328,057
Net cash used in financing and miscellaneous activities	(23,990,218)	(68,916,781)
RECONCILIATION OF CASH AND CASH EQUIVALENTS:		
NET CHANGE IN CASH AND CASH EQUIVALENTS	59,579,114	61,227,639
CASH AND CASH EQUIVALENTS — Beginning of year	68,901,496	7,673,857
CASH AND CASH EQUIVALENTS — End of year	$ 128,480,610	$ 68,901,496

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF THE MIDWEST, INC.

NOTES TO STATUTORY BASIS FINANCIAL STATEMENTS
AS OF AND FOR THE YEARS ENDED DECEMBER 31, 2020 AND 2019

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GOING CONCERN

Organization and Operation

UnitedHealthcare of the Midwest, Inc. (the "Company"), licensed as a health maintenance organization ("HMO"), offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. The Company is a wholly owned subsidiary of UnitedHealthcare, Inc. ("UHC"). UHC is a wholly owned subsidiary of United HealthCare Services, Inc. ("UHS"), a management corporation that provides services to the Company under the terms of a management agreement (the "Agreement"). UHS is a wholly owned subsidiary of UnitedHealth Group Incorporated ("UnitedHealth Group"). UnitedHealth Group is a publicly held company trading on the New York Stock Exchange.

The Company was incorporated on February 26, 1985, as an HMO and operations commenced in August 1985. The Company is certified as an HMO by the Missouri Department of Insurance (the "Department"). The Company has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees. As of December 31, 2020, the Company is licensed in five states.

The Company offers comprehensive commercial products to individuals. The contract outlines the coverage provided and renewal provisions. Effective January 1, 2017, the Company exited the Affordable Care Act ("ACA") individual exchange market in Kansas and Illinois.

The Company has a contract with the Centers for Medicare and Medicaid Services ("CMS") to serve as a plan sponsor offering a Dual Special Needs Plan ("DSNP") product. This product is solely funded by CMS. A DSNP is a specialized type of Medicare Advantage Prescription Drug Plan ("MAPD") that is limited to dually eligible members and provides additional Medicaid coordination and clinical programs (collectively "Medicare Plans").

The Company has a contract with the State of Kansas Department of Health and Environment ("KDHE"), to provide health care services to Medicaid and Children's Health Insurance Program ("CHIP", a program for uninsured children) eligible beneficiaries in Kansas. The current contract is effective through December 31, 2021, and is subsequently subject to annual renewal options through December 31, 2023.

The Company has a contract with the State of Missouri Department of Social Services, Missouri HealthNet Division ("HealthNet"), to provide health care services to Medicaid and CHIP eligible beneficiaries in Missouri. The current contract is effective through June 30, 2021, and is subject to annual renewal provisions thereafter.

A. Accounting Practices

The statutory basis financial statements of the Company are presented on the basis of accounting practices prescribed or permitted by the Department.

The Department recognizes only statutory accounting practices, prescribed or permitted by the State of Missouri, for determining and reporting the financial condition and results of operations of an HMO, for determining its solvency under Missouri Insurance Law. The state prescribes the use of the National Association of Insurance Commissioners' ("NAIC") Accounting Practices and Procedures manual ("NAIC SAP") in effect for the accounting periods covered in the statutory basis financial statements.

The Department has adopted certain prescribed accounting practices that differ from those found in the NAIC SAP. A reconciliation of the Company's net income and capital and surplus between the NAIC SAP and practices prescribed by the Department is shown below:

Net Income	SSAP #	AFS Line #	December 31, 2020	December 31, 2019
(1) Company state basis	XXX	XXX	$ 94,973,204	$ 32,657,439
(2) State prescribed practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(3) State permitted practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	XXX	XXX	$ 94,973,204	$ 32,657,439
Capital and Surplus				
(5) Company state basis	XXX	XXX	$ 256,424,522	$ 202,916,835
(6) State prescribed practices that are an increase/(decrease) from NAIC SAP: 20 CSR 200-1.040(3)(B) - Nonadmit prepaid premium taxes			(7,241)	(8,376)
(7) State permitted practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(8) NAIC SAP (5 - 6 - 7 = 8)	XXX	XXX	$ 256,431,763	$ 202,925,211

Prepaid premium taxes of $7,241 and $8,376 as of December 31, 2020 and 2019, respectively, are required to be nonadmitted per Missouri Regulation 20 CSR 200-1.040. There was no impact to net income and no regulatory risk-based capital ("RBC") event was triggered from the Company using the Missouri statute.

B. Use of Estimates in the Preparation of the Statutory Basis Financial Statements

The preparation of these statutory basis financial statements in conformity with the NAIC Annual Statement Instructions and the NAIC SAP include certain amounts that are based on the Company's estimates and judgments. These estimates require the Company to apply complex assumptions and judgments, often because the Company must make estimates about the effects of matters that are inherently uncertain and will change in subsequent periods. The most significant estimates relate to hospital and medical benefits, claims unpaid, aggregate health policy reserves (including medical loss ratio rebates and premium deficiency reserves ("PDR")), aggregate health claim reserves, and risk adjustment estimates. The Company adjusts these estimates each period as more current information becomes available. The impact of any changes in estimates is included in the determination of net income in the period in which the estimate is adjusted.

C. Accounting Policy

Basis of Presentation — The Company prepares its statutory basis financial statements on the basis of accounting practices prescribed or permitted by the Department. These statutory practices differ from accounting principles generally accepted in the United States of America ("GAAP").

Accounting policy disclosures that are required by the NAIC Annual Statement instructions are as follows:

(1–2) Bonds are stated at book/adjusted carrying value if they meet NAIC designation of one or two and stated at the lower of book/adjusted carrying value or fair value if they meet an NAIC designation of three or higher. The Company does not have any mandatory convertible securities or Securities Valuation Office of the NAIC ("SVO") identified funds (i.e.: exchange traded funds or bond mutual funds) in its bond portfolio. Amortization of bond premium or accretion of discount is calculated using the constant-yield interest method. Bonds are valued and reported using market prices published by the SVO in accordance with the NAIC Valuation of Securities manual prepared by the SVO or an external pricing service;

(3–4) The Company holds no common or preferred stock;

(5) The Company holds no mortgage loans on real estate;

(6) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the book/adjusted carrying value, commonly referred to as amortized cost, of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors. The Company's investment policy limits investments in nonagency residential mortgage-backed securities, including home equity and sub-prime mortgages, to 10% of total cash and invested assets. Total combined investments in mortgage-backed securities and asset-backed securities cannot exceed more than 30% of total cash and invested assets;

(7) The Company holds no investments in subsidiaries, controlled, or affiliated entities;

(8) The Company has no investment interests with respect to joint ventures, partnerships, or limited liability companies;

(9) The Company holds no derivatives;

(10) PDR (inclusive of conversion reserves) and the related expenses are recognized when it is probable that expected future health care expenses, claims adjustment expenses ("CAE"), direct administration costs, and an allocation of indirect administration costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries considered over the remaining lives of the contracts, and are recorded as aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Indirect administration costs arise from activities that are not specifically identifiable to a specific group of existing contracts, and therefore, those costs are fully allocated among the various contract groupings. The allocation of indirect administration costs to each contract grouping is made proportionately to the expected margins remaining in the premiums after future health care expenses, CAE, and direct administration costs are considered. The data and assumptions underlying such estimates and the resulting reserves are periodically updated, and any adjustments are reflected as an increase or decrease in reserves for accident and health contracts in the statutory basis statements of operations in the period in which the change in estimate is identified. The Company does anticipate investment income as a factor in the PDR calculation (see Note 30);

(11) CAE are those costs expected to be incurred in connection with the adjustment and recording of accident and health claims. Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to its affiliate, UHS, in exchange for

administrative and management services. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and general administrative expenses ("GAE") to be reported in the statutory basis statements of operations. It is the responsibility of UHS to pay CAE in the event the Company ceases operations. The Company has recorded an estimate of unpaid CAE associated with incurred but unpaid claims, which is included in unpaid CAE in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Management believes the amount of the liability for unpaid CAE as of December 31, 2020 is adequate to cover the Company's cost for the adjustment and recording of unpaid claims; however, actual expenses may differ from those established estimates. Adjustments to the estimates for unpaid CAE are reflected in operating results in the period in which the change in estimate is identified;

(12) The Company does not carry any fixed assets in the statutory basis financial statements;

(13) Health care receivables consist of pharmacy rebates receivable estimated based on the most currently available data from the Company's claims processing systems and from data provided by the Company's affiliated pharmaceutical benefit manager, OptumRx, Inc. ("OptumRx"). Health care receivables also include receivables for amounts due to the Company for provider advances and claim overpayments to providers, hospitals and other health care organizations. In addition, the Company has agreements with certain independent physicians and physician network organizations that provide for the establishment of a fund into which the Company places monthly premiums payable for members assigned to the physician. The Company manages the disbursement of funds from this account as well as reviews the utilization of nonprimary care medical services of members assigned to the physicians. Any deficits in the fund are shared by the Company and the physician based upon predetermined risk-sharing percentages and any associated receivable is included in health care receivables. Health care receivables are considered nonadmitted assets under the NAIC SAP if they do not meet admissibility requirements. Accordingly, the Company has excluded receivables that do not meet the admissibility criteria from the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 28).

The Company has also deemed the following to be significant accounting policies and/or differences between statutory practices and GAAP:

ASSETS

Cash and Invested Assets

- Bonds include U.S. government and agency securities, state and agency municipal securities, city and county municipal securities, and corporate debt securities, with a maturity of greater than one year at the time of purchase;

- Certain debt investments categorized as available-for-sale or held-to-maturity under GAAP are presented at the lower of book/adjusted carrying value or fair value in accordance with the NAIC designations in the statutory basis financial statements, whereas under GAAP, these investments are shown at fair value or book/adjusted carrying value, respectively;

- Cash and cash equivalents in the statutory basis financial statements represent cash balances and investments with original maturities of one year or less from the time of acquisition, whereas under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and investments that will mature in one year or less from the balance sheet date;

- Cash represents cash held by the Company in disbursement accounts. Claims and other payments are made from the disbursement accounts daily;

- Outstanding checks are required to be netted against cash balances or presented as cash overdrafts if in excess of cash balances in the statutory basis statements of admitted assets, liabilities, and capital and surplus as opposed to being presented as other liabilities under GAAP;

- Cash equivalents include money-market funds. Cash equivalents have original maturity dates of three months or less from the date of acquisition. Money-market funds are reported at fair value or net asset value ("NAV") as a practical expedient;

- Realized capital gains and losses on sales of investments are calculated based upon specific identification of the investments sold. These gains and losses are reported as net realized capital (losses) gains less capital gains tax (benefit) expense in the statutory basis statements of operations;

- The Company continually monitors the difference between amortized cost and estimated fair value of its investments. If any of the Company's investments experience a decline in value that the Company has determined is other-than-temporary, or if the Company has determined it will sell a security that is in an impaired status, the Company will record a realized loss in net realized capital losses less benefits. The new cost basis is not changed for subsequent recoveries in fair value. The prospective adjustment method is utilized for loan-backed securities for periods subsequent to the loss recognition. The Company recognized an other-than-temporary impairment ("OTTI") of $31,392 and $0 for the years ended December 31, 2020 and 2019, respectively;

- The NAIC SAP requires the following captions to be taken into consideration in the reconciliation of the statutory basis statements of cash flows: cash, including cash overdrafts, cash equivalents, and short-term investments, which can include restricted cash reserves, with original maturities of one year or less from the time of acquisition, whereas under GAAP, pursuant to Accounting Standards Update 2016-18, *Statement of Cash Flows, Restricted Cash*, the statements of cash flows reconcile the corresponding captions of cash, cash equivalents and restricted cash with maturities of three months or less. Short-term investments with a final maturity of one year or less from the balance sheet date are not included in the reconciliation of GAAP cash flows. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and NAIC SAP. The statutory basis statements of cash flows are prepared in accordance with the NAIC Annual Statement Instructions.

Other Assets

- **Investment Income Due and Accrued** — Investment income earned and due as of the reporting date, in addition to investment income earned but not paid or collected until subsequent periods, is reported as investment income due and accrued in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company evaluates the collectability of the amounts due and accrued and amounts determined to be uncollectible are written off in the period in which the determination is made. In addition, the remaining balance is assessed for admissibility and any balance greater than 90 days past due is considered a nonadmitted asset.

- **Premiums and Considerations** — The Company reports uncollected premium balances from its insured members, CMS, and state Medicaid agencies as premiums and considerations in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Uncollected premium balances that are over 90 days past due, with the

exception of amounts due from government insured plans, are considered nonadmitted assets. In addition to those balances, current balances are also considered nonadmitted if the corresponding balance greater than 90 days past due is deemed more than inconsequential. Premiums and considerations also include the following (see Note 24):

a) CMS risk corridor receivables for which adjustments are based on whether the ultimate per member per month ("PMPM") benefit costs of any Medicare Plan varies more than 5% above the level estimated in the original bid submitted by the Company and approved by CMS;

b) CMS risk adjustment receivables for the Medicare Plans. The risk adjustment model apportions premiums paid to all health plans according to the health severity and certain demographic factors of its enrollees. The CMS risk adjustment model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk-adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, and physician treatment settings. The Company and health care providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS. The Company recognizes such changes when the amounts become determinable and supportable and collectability is reasonably assured;

c) KDHE pay for performance receivable. The pay for performance program is based upon the Company's performance against various quality and operation measures established in the Company's contract with KDHE. The pay for performance receivable is calculated as a percentage of a monthly capitation payment received from the State of Kansas;

d) HealthNet pay for performance receivable. The pay for performance program is based upon the Company's performance against various quality and operational measures established in the Company's contract with HealthNet. The pay for performance receivable is calculated as a percentage of a monthly capitation payment received from the State of Missouri.

Premium adjustments for the CMS risk corridor program are accounted for as premium adjustments subject to retrospectively rated features. Premium adjustments for the CMS risk adjustment and pay for performance programs are accounted for as premium adjustments subject to redetermination (see Note 24).

- **Amounts Receivable Relating to Uninsured Plans** — The Company reports amounts due to the Company from CMS for the administrative activities it performs for which it has no insurance risk as amounts receivable relating to uninsured plans (see Note 18). Amounts receivable relating to uninsured plans include the following:

  a) costs incurred in excess of the cost reimbursement under the Medicare Plans for the catastrophic reinsurance subsidy and the low-income member cost-sharing subsidy for the individual members. The Company is fully reimbursed by CMS for costs incurred for these contract elements, and accordingly, there is no insurance risk to the Company. Subsidies for individual members are received monthly and are not reflected as net premium income, but rather are accounted for as deposits. If the Company incurs costs in excess of these subsidies, a corresponding receivable is recorded. The low-income member cost-sharing subsidy for employer group members is only received at settlement which is in the subsequent year; and

b) the Patient Protection and ACA and its related legislation mandates consumer discounts of 70% on brand name prescription drugs for Part D plan participants in the coverage gap. As part of the Coverage gap discount program, the Company records a receivable from the pharmaceutical manufacturers for reimbursement of the discounts. The Company solely administers the application of these funds and has no insurance risk.

- **Current Federal Income Tax Recoverable** — The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group, under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses, the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UnitedHealth Group. A current federal income tax recoverable is recognized when the Company's allocated intercompany estimated payments are more than its actual calculated obligation based on the Company's stand-alone federal income tax return (see Note 9).

- **Net Deferred Tax Asset** — The NAIC SAP provides for an amount to be recorded for deferred taxes on temporary differences between the financial reporting and tax bases of assets, subject to a valuation allowance and admissibility limitations on deferred tax assets (see Note 9). In addition, under the NAIC SAP, the change in deferred tax assets is recorded directly to unassigned surplus in the statutory basis financial statements, whereas under GAAP, the change in deferred tax assets is recorded as a component of the income tax provision within the income statement and is based on the ultimate recoverability of the deferred tax assets. Based on the admissibility criteria under the NAIC SAP, any deferred tax assets determined to be - 13 -onadmitted are charged directly to surplus and excluded from the statutory basis financial statements, whereas under GAAP, such assets are included in the balance sheet.

- **Receivables from Parent, Subsidiaries, and Affiliates, Net** — In the normal course of business, the Company has various transactions with related parties (see Note 10). The Company reports any unsettled amounts due as receivables from parent, subsidiaries, and affiliates, net, in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company has excluded receivables that do not meet the admissibility criteria from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

LIABILITIES

- **Claims Unpaid and Aggregate Health Claim Reserves** — Claims unpaid and aggregate health claim reserves include claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees have received but for which claims have not yet been submitted, and payments and liabilities for physician, hospital, and other medical costs disputes.

  The estimates for incurred but not yet reported claims are developed using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as historical submission and payment data, cost trends, customer and product mix, seasonality, utilization of health care services, contracted service rates, and other relevant factors. The Company estimates such liabilities for physician, hospital, and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. These estimates may change as actuarial methods change or as underlying facts upon which estimates are based change. The Company did not change actuarial methods during 2020 and 2019.

Management believes the amount of claims unpaid and aggregate health claim reserves is a best estimate of the Company's liability for unpaid claims and aggregate health claim reserves as of December 31, 2020; however, actual payments may differ from those established estimates.

The reserves ceded to reinsurers for claims unpaid and aggregate health claim reserves have been reported as reductions of the related reserves rather than as assets, which would be required under GAAP.

The Company contracts with hospitals, physicians, and other providers of health care under capitated or discounted fee for service arrangements, including a hospital per diem to provide medical care services to enrollees. Some of these contracts are with related parties (see Note 10). Capitated providers are at risk for the cost of medical care services provided to the Company's enrollees; however, the Company is ultimately responsible for the provision of services to its enrollees should the capitated provider be unable to provide the contracted services.

- **Accrued Medical Incentive Pool and Bonus Amounts** — The Company has agreements with certain independent physicians and physician network organizations that provide for the establishment of a fund into which the Company places monthly premiums payable for members assigned to the physician. The Company manages the disbursement of funds from this account as well as reviews the utilization of nonprimary care medical services of members assigned to the physicians. Any surpluses in the fund are shared by the Company and the physician based upon predetermined risk-sharing percentage and the liability is included in accrued medical incentive pool and bonus amounts in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company also has incentive and bonus arrangements with providers that are based on quality, utilization, and/or various health outcome measures. The estimated amount due to providers that meet the established metrics is included in accrued medical incentive pool and bonus amounts in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Aggregate Health Policy Reserves** — Aggregate health policy reserves includes:

  a) CMS risk adjustment payables for the Medicare Plans. The risk adjustment model apportions premiums paid to all health plans according to the health severity and certain demographic factors of its Medicare Plans enrollees. The CMS risk adjustment model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk-adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, and physician treatment settings. The Company and health care providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. If diagnosis data submitted to CMS needs to be corrected or deleted, the revised diagnosis data can be re-submitted. The Company estimates reductions to risk adjustment revenues and corresponding change in CMS risk adjustment payables based upon the diagnosis data submitted and expected to be submitted to CMS. The Company recognizes such changes when the amounts become determinable and supportable (see Note 24);

  b) estimated rebates payable on the Medicare Plans, if the medical loss ratios on this fully insured product, as calculated under the definitions of the ACA and implementing regulations, fall below certain targets. The Company is required to rebate the ratable portions of the premiums annually (see Note 24);

c) KDHE pay for performance. The pay for performance program is based upon the Company's performance against various quality measures established in the Company's contract with the KDHE. The unearned pay for performance reserve is calculated as a percentage of a monthly capitation payment received from the State of Kansas (see Note 24);

d) risk corridor payables due to the KDHE, net of reinsurance, to address the uncertainty of medical costs given the COVID-19 pandemic. Risk corridor amounts are recorded when the Company incurs benefit costs for KDHE members that are less than 95%, or more than 105%, of the target amount set by the KDHE for products subject to the corridor (see Note 24); and

e) the estimated amount for PDR (see Note 30).

- **Premiums Received in Advance** — Premiums received in full for the policies processed during the current period, but prior to the commencement of the service period, are recorded as premiums received in advance in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **General Expenses Due or Accrued** — General expenses that are due as of the reporting date in addition to general expenses that have been incurred but are not due until a subsequent period are reported as general expenses due or accrued in the statutory basis statements of admitted assets, liabilities, and capital and surplus. General expenses due or accrued also include the amounts for commissions payable, premium taxes, and state income taxes (see Note 24).

- **Current Federal Income Tax Payable** — The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses, the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UnitedHealth Group. A liability for federal income taxes payable is recognized when its allocated intercompany estimated payments are less than its actual calculated obligation based on the Company's stand-alone federal income tax return (see Note 9).

- **Remittances and Items Not Allocated** — Remittances and items not allocated generally represent monies received from policyholders for monthly premium billings or providers that have not been specifically identified or applied prior to year-end. The majority is from monies received in the lockbox account on the last day of the year.

- **Amounts Due to Parent, Subsidiaries, and Affiliates, Net** — In the normal course of business, the Company has various transactions with related parties (see Note 10). The Company reports any unsettled amounts owed as amounts payable to parent, subsidiaries, and affiliates, net, in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Liability for Amounts Held Under Uninsured Plans** — Liability for amounts held under uninsured plans represents amounts due from the Company to CMS and provider agencies for the administrative activities it performs for which it has no insurance risk (see Note 18). Liability for amounts held under uninsured plans includes the following:

  a) the ACA mandates consumer discounts of 70% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are pre-funded for the individual members by CMS and a liability for the amount subject to recoupment is recorded. The Company solely administers the application of these funds and has no insurance risk.

b) Payments received from the HealthNet's Federal Reimbursement Allowance ("FRA") program include an amount due to the provider. Disbursements are passed through to the provider on a monthly basis and are based on per member claim utilization. The Company assumes no risk and does not recognize any premium revenue or medical benefit expenses.

c) Payments received from HealthNet's Show Me Echo program include an amount due to the provider. Disbursements are passed through to the provider on a monthly basis and are based on number of members. The Company assumes no risk and does not recognize any premium revenue or medical benefit expenses.

d) Payments received from HealthNet's Medicaid Access to Physician ("MAPS") program include an amount due to the provider. Disbursement are passed through to the provider on a quarterly basis and are based on per member claims utilization. The Company assumes no risk and does not recognize any premium revenue or medical benefit expenses.

CAPITAL AND SURPLUS AND MINIMUM STATUTORY REQUIREMENTS

- **Nonadmitted Assets** — Certain assets, including certain aged premium receivables, certain health care receivables, prepaid expenses, and amounts receivable relating to uninsured plans, are considered nonadmitted assets under the NAIC SAP and are excluded from the statutory basis statements of admitted assets, liabilities, and capital and surplus and charged directly to unassigned surplus. Under GAAP, such assets are included in the balance sheet.

- **Restricted Cash Reserves** — The Company held regulatory deposits in the amount of $912,943 and $920,834 as of December 31, 2020 and 2019, respectively, in compliance with the state requirements for qualification purposes as a domestic and foreign insurer. These restricted cash reserves consist principally of government obligations and are stated at book/adjusted carrying value, which approximates fair value. These restricted deposits are included in bonds in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Interest earned on these deposits accrues to the Company.

- **Minimum Capital and Surplus** — Under the laws of the State of Missouri, the Company's domiciliary state, the Department requires the Company to maintain a minimum capital and surplus equal to 2% of the prior year net premium income, or $24,798,269 and $17,393,129 as of December 31, 2020 and 2019, respectively. The Company is in compliance with the required amount.

  RBC is a regulatory tool for measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. The Department requires the Company to maintain minimum capital and surplus equal to the greater of the state statute as outlined above, or the company action level as calculated by the RBC formula, or the level needed to avoid action pursuant to the trend test in the RBC formula. The Company is in compliance with the required amount.

  The Company is also subject to minimum capital and surplus requirements in other states where it is licensed to do business.

  The Company has $256,424,522 and $202,916,835 in total statutory basis capital and surplus as of December 31, 2020 and 2019, respectively, which is in compliance with the required amounts where it is licensed to do business.

- **Section 9010 ACA Subsequent Fee Year Assessment** — The Company is subject to the Section 9010 ACA subsequent fee year assessment. Under the NAIC SAP, as of December, 31, 2019, an amount equal to the estimated subsequent year fee was apportioned out of unassigned surplus and reported as Section 9010 ACA subsequent fee year assessment, in the statutory basis statements of admitted assets, liabilities, and capital and surplus, whereas under GAAP, no such special surplus designation is required. In accordance with the 2021 Health Insurer Fee ("HIF") repeal, no HIF will be payable in 2021 or thereafter, therefore no amounts will be apportioned out of unassigned surplus after December 31, 2019.

STATEMENTS OF OPERATIONS

- **Net Premium Income and Change in Reserve for Rate Credits** — Revenues consist of net premium income that is recognized in the period in which enrollees are entitled to receive health care services. Net premium income is shown net of reinsurance premiums paid and reinsurance premiums incurred but not paid in the statutory basis statements of operations.

  Comprehensive commercial health plans with medical loss ratios on fully insured products, as calculated under the definitions in the ACA and implementing regulations, that fall below certain targets are required to rebate ratable portions of premiums annually. The Company classifies its estimated rebates as change in reserve for rate credits in the statutory basis statements of operations.

  Net premium income includes premiums under the Medicare Plans which includes CMS premiums, including amounts pursuant to the CMS risk adjustment program and the CMS low-income premium subsidy for the Company's insurance risk coverage. Net premium income is recognized ratably over the period in which eligible individuals are entitled to receive health care services and prescription drug benefits.

  The Company also records estimates related to the CMS Medicare Plans risk corridor program. Changes to these estimates are reflected as change in reserve for rate credits in the statutory basis statements of operations.

  The Company's Medicare Plans are subject to medical loss ratio requirements under the ACA. Plans with medical loss ratios that fall below certain targets are required to rebate ratable portions of premiums annually. The Company classifies its estimated rebates as change in reserve for rate credits in the statutory basis statements of operations.

  Net premium income also includes amounts paid by state and federal governments on a per member basis in exchange for the provision and administration of medical benefits under the Medicaid and CHIP programs. Premiums are contractual and are recognized in the coverage period in which members are entitled to receive services, except in the case of maternity payments. Maternity income is billed on contractual rates and recognized as income as each birth case is identified by the Company. Included in net premium income are capitated payments and maternity payments. The majority of net premium income recorded is based on capitated rates, which are monthly premiums paid for each member enrolled.

- **Total Hospital and Medical Expenses** — Total hospital and medical expenses include claims paid, claims processed but not yet paid, estimates for claims received but not yet processed, estimates for the costs of health care services enrollees have received but for which claims have not yet been submitted, and payments and liabilities for physician, hospital, and other medical costs disputes.

Total hospital and medical expenses also include amounts incurred for incentive pool, withhold adjustments, and bonus amounts that are based on the underlying contractual provisions with the respective providers. In addition, adjustments to claims unpaid estimates and aggregate health claim reserves are reflected in the period once the change in estimate is identified and included in total hospital and medical expenses in the statutory basis statements of operations.

- **General Administrative Expenses** — Pursuant to the terms of the Agreement (see Note 10), the Company pays a management fee to UHS exchange for administrative and management services. Costs for items not included within the scope of the Agreement are directly expensed as incurred. State income taxes are also a component of GAE. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and GAE to be reported in the statutory basis statements of operations.

  The Company is subject to an annual fee under Section 9010 of the ACA. A health insurance entity's annual fee becomes payable once the entity provides health insurance for any U.S. health risk during the calendar year, which is nondeductible for tax purposes (see Note 22). Under the NAIC SAP, the entire amount of the estimated annual fee expense is recognized on January 1 of the fee year in GAE in the statutory basis statements of operations, whereas under GAAP, a deferred asset is created on January 1 of the fee year which is amortized to expense on a straight-line basis throughout the year.

- **Net Investment Income Earned** — Net investment income earned includes investment income collected during the period, as well as the change in investment income due and accrued on the Company's holdings. Amortization of premium or discount on bonds and certain external investment management costs are also included in net investment income earned (see Note 7).

- **Federal Income Taxes Incurred** — The provision for federal income taxes incurred is calculated based on applying the statutory federal income tax rate of 21% to net income before federal income taxes and net realized capital losses (gains) subject to certain adjustments (see Note 9).

- **Comprehensive Income** — Comprehensive income and its components are not separately presented in the statutory basis financial statements, whereas under GAAP, it is a requirement to present comprehensive income and its components in the financial statements.

REINSURANCE

- **Reinsurance Ceded** — In the normal course of business, the Company seeks to limit its exposure to loss on any single insured and to recover a portion of benefits paid by ceding premium to other insurance enterprises or reinsurers under excess coverage contracts or specific transfer of risk agreements. The Company remains primarily liable as the direct insurer on the risks reinsured. Reinsurance premiums paid and reinsurance premiums incurred but not paid are deducted from net premium income in the statutory basis statements of operations. Any amounts due to the Company pursuant to these agreements are recorded as amounts recoverable from reinsurers in the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 23).

  The Company has a reinsurance agreement through which 60% of comprehensive commercial and Medicaid earned member premiums, hospital and medical benefits, and operating expenses are ceded to the reinsurer. These amounts are reflected as a reduction to net premium income, change in reserves for rate credits, total hospital and medical,

CAE, and GAE in the statutory basis financial statements. Pursuant to the quota share agreement, the Company records amounts recoverable from the reinsurer for claims paid, GAE, and CAE as amounts recoverable from reinsurers and estimates of claims incurred but not yet paid as a reduction to claims unpaid in the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 23).

The Company has an insolvency-only reinsurance agreement with UnitedHealthcare Insurance Company ("UHIC"), an affiliate whereby 0.1% of net premium income is ceded to UHIC (see Note 23).

- **Amounts Recoverable from Reinsurers** — The Company records coinsurance cost share within amounts recoverable from reinsurers in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as net reinsurance recoveries in the statutory basis statements of operations.

- **Ceded Reinsurance Premiums Payable** — The ceded reinsurance premiums payable balance represents amounts due to the reinsurers for specified coverage which will be paid based on the contract terms.

OTHER

- **Vulnerability Due to Certain Concentrations** — The Company is subject to substantial federal and state government regulation, including licensing and other requirements relating to the offering of the Company's existing products in new markets and offerings of new products, both of which may restrict the Company's ability to expand its business.

  The Company has no commercial customers that individually exceed 10% of total direct premiums written and premiums and considerations for the years ended December 31, 2020 and 2019.

  Direct premiums written and premiums and considerations, including receivables for contracts subject to redetermination, from members and CMS related to the Medicare Plans as a percentage of total direct premiums written and total premiums and considerations, including receivables for contracts subject to redetermination, are 27% and 5% as of December 31, 2020 and 22% and 6% as of December 31, 2019, respectively.

  Direct premiums written and premiums and considerations, including receivables for contracts subject to redetermination, from the KDHE as a percentage of total direct premiums written and total premiums and considerations, including receivables for contracts subject to redetermination, are 51% and 66% as of December 31, 2020 and 56% and 64% as of December 31, 2019, respectively. Direct premiums written and uncollected premiums, including receivables for contracts subject to redetermination, from HealthNet as a percentage of total direct premiums written and total premiums and considerations, including receivables for contracts subject to redetermination, are 22% and 29% as of December 31, 2020 and 22% and 29% as of December 31, 2019, respectively.

Recently Issued Accounting Standards — The Company reviewed all recently issued guidance in 2020 and 2019 that has been adopted for 2020 or subsequent years' implementation and has determined that none of the items would have a significant impact to the statutory basis financial statements.

D. Going Concern

The Company has the ability and will continue to operate for a period of time sufficient to carry out its commitments, obligations and business objectives.

2. ACCOUNTING CHANGES AND CORRECTIONS OF ERRORS

No changes in accounting principles or corrections of errors have been recorded during the years ended December 31, 2020 and 2019.

3. BUSINESS COMBINATIONS AND GOODWILL

A–D. The Company was not party to a business combination during the years ended December 31, 2020 and 2019, and does not carry goodwill in its statutory basis statements of admitted assets, liabilities, and capital and surplus.

4. DISCONTINUED OPERATIONS

A. Discontinued Operation Disposed of or Classified as Held for Sale

(1–4) The Company did not have any discontinued operations disposed of or classified as held for sale during 2020 and 2019.

B. Change in Plan of Sale of Discontinued Operation — Not applicable.

C. Nature of any Significant Continuing Involvement with Discontinued Operations after Disposal — Not applicable.

D. Equity Interest Retained in the Discontinued Operation after Disposal — Not applicable.

5. INVESTMENTS

For purposes of calculating gross realized gains and losses on sales of investments, the amortized cost of each investment sold is used. The gross realized gains and losses on sales of long-term investments were $20,513 and $19,838, respectively, for 2020 and $384,812 and $45,232, respectively, for 2019. There were no gross realized gains or losses on sales of short-term investments in 2020 or 2019. The net realized gain is included in net realized capital (losses) gains less capital gains tax (benefit) expense. Total proceeds on the sale of long-term investments were $289,439 and $24,619,991 in 2020 and 2019, respectively. There were no proceeds on sale of short-term investments in 2020 and 2019.

As of December 31, 2020 and 2019, the book/adjusted carrying value, fair value, and gross unrecognized unrealized gains and losses of the Company's investments, excluding cash and cash equivalents of $128,480,610 and $68,901,496 respectively, are disclosed in the table below.

	2020				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 13,209,165	$ 773,560	$ 3,691	$ -	$ 13,979,034
State and agency municipal securities	5,169,379	456,820	-	-	5,626,199
City and county municipal securities	8,913,636	627,489	-	-	9,541,125
Corporate debt securities	24,769,739	1,511,394	4,763	13,044	26,263,326
Total bonds	$ 52,061,919	$ 3,369,263	$ 8,454	$ 13,044	$ 55,409,684

	2020				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
Less than one year	$ 1,760,557	$ 18,935	$ -	$ -	$ 1,779,492
One to five years	14,195,110	759,226	-	-	14,954,336
Five to ten years	19,422,046	1,856,051	1,741	-	21,276,356
Over ten years	16,684,206	735,051	6,713	13,044	17,399,500
Total bonds	$ 52,061,919	$ 3,369,263	$ 8,454	$ 13,044	$ 55,409,684

	2019				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 13,733,695	$ 355,121	$ 9,757	$ -	$ 14,079,059
State and agency municipal securities	5,232,927	295,667	-	-	5,528,594
City and county municipal securities	8,069,280	400,346	-	-	8,469,626
Corporate debt securities	23,883,867	714,017	6,267	3,416	24,588,201
Total bonds	$ 50,919,769	$ 1,765,151	$ 16,024	$ 3,416	$ 52,665,480

Included in U.S. government and agency securities and corporate debt securities in the tables above are mortgage-related loan-backed securities, which do not have a single maturity date. For the years to maturity table above, these securities have been presented in the maturity group based on the securities' final maturity date and at a book/adjusted carrying value of $13,654,655 and fair value of $14,254,753.

The following table illustrates the fair value and gross unrecognized unrealized losses, aggregated by investment category and length of time that the individual securities have been in a continuous unrecognized unrealized loss position as of December 31, 2020 and 2019:

	2020					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 877,971	$ 3,691	$ -	$ -	$ 877,971	$ 3,691
Corporate debt securities	709,265	4,763	386,956	13,044	1,096,221	17,807
Total bonds	$ 1,587,236	$ 8,454	$ 386,956	$ 13,044	$ 1,974,192	$ 21,498

	2019					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 1,610,661	$ 9,757	$ -	$ -	$ 1,610,661	$ 9,757
Corporate debt securities	2,397,075	6,267	622,948	3,416	3,020,023	9,683
Total bonds	$ 4,007,736	$ 16,024	$ 622,948	$ 3,416	$ 4,630,684	$ 19,440

The unrecognized unrealized losses on investments in U.S. government and agency securities and corporate debt securities at December 31, 2020 and 2019, were mainly caused by interest rate fluctuations and not by unfavorable changes in the credit ratings associated with these securities. The Company evaluates impairment at each reporting period for each of the securities whereby the fair value of the investment is less than its book/adjusted carrying value. The contractual cash flows of the U.S. government and agency securities are guaranteed either by the U.S. government or an agency of the U.S. government. It is expected that the securities would not be settled at a price less than the cost of the investment, and the Company does not intend to sell the investment until the unrealized loss is fully recovered. The Company assessed the credit quality of the state and agency municipal securities, city and county municipal securities, and corporate debt securities, noting whether a significant deterioration since purchase or other factors that may indicate an OTTI, such as the length of time and extent to which fair value has been less than cost, the financial condition, and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the investment. Additionally, the Company evaluated its intent and ability to retain loan-backed securities for a period of time sufficient to recover the amortized cost. As a result of these reviews, the Company recorded an OTTI of $31,392 and $0 as of December 31, 2020 and 2019, respectively, which are included in net realized capital (losses) gains less capital gains tax (benefit) expense.

A–C. The Company has no mortgage loans, real estate loans, restructured debt, or reverse mortgages. The Company also has no real estate property occupied by the Company, real estate property held for the production of income, or real estate property held for sale.

D. Loan-Backed Securities

(1) U.S. government and agency securities and corporate debt securities include loan-backed securities (mortgage-backed securities and asset-backed securities), which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the book/adjusted carrying value, commonly referred to as amortized cost, of loan-backed securities are based on a three-month constant prepayment rate history obtained from external data source vendors.

(2) The Company did not recognize any OTTI on loan-backed securities as of December 31, 2020 and 2019.

(3) The Company did not have any loan-backed securities with OTTIs to report by CUSIP as of December 31, 2020 or 2019.

(4) The following table illustrates the fair value, gross unrecognized unrealized losses, and length of time that the loan-backed securities have been in a continuous unrecognized unrealized loss position as of December 31, 2020 and 2019:

		2020
The aggregate amount of unrealized losses:		
1. Less than 12 months	$	3,691
2. 12 months or longer		13,044
The aggregate related fair value of securities with unrealized losses:		
1. Less than 12 months		924,107
2. 12 months or longer		386,956

		2019
The aggregate amount of unrealized losses:		
1. Less than 12 months	$	11,402
2. 12 months or longer		3,229
The aggregate related fair value of securities with unrealized losses:		
1. Less than 12 months		2,282,994
2. 12 months or longer		569,563

(5) The Company believes that it will continue to collect timely the principal and interest due on its loan-backed securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate changes and not by unfavorable changes in the credit quality associated with these securities that impacted the assessment on collectability of principle and interest. At each reporting period, the Company evaluates available-for-sale debt securities for any credit-related impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the expected cash flows, the underlying credit quality and credit ratings of the issuers, and the potential economic impacts of COVID-19 on the issuers, noting no significant credit deterioration since purchase. As of December 31, 2020, the unrealized loss on any security that the Company classified as intent to sell was not material to the Company's investment portfolio. Any other securities in an unrealized loss position as of December 31, 2020, the Company considers to be temporary.

E. **Dollar Repurchase Agreements and/or Securities Lending Transactions** — Not applicable.

F. **Repurchase Agreements Transactions Accounted for as Secured Borrowing** — Not applicable.

G. **Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing** — Not applicable.

H. **Repurchase Agreements Transactions Accounted for as a Sale** — Not applicable.

I. **Reverse Repurchase Agreements Transactions Accounted for as a Sale** — Not applicable.

J. Real Estate — Not applicable.

K. Low-Income Housing Tax Credits — Not applicable.

L. Restricted Assets —

(1) Restricted assets, including pledged securities as of December 31, 2020 and 2019, are presented below:

Restricted Asset Category	1 Total Gross (Admitted & Nonadmitted) Restricted From Current Year	2 Total Gross (Admitted & Nonadmitted) Restricted From Prior Year	3 Increase/ (Decrease) (1 Minus 2)	4 Total Current Year Nonadmitted Restricted	5 Total Current Year Admitted Restricted (1 minus 4)	6 Gross (Admitted & Nonadmitted) Restricted to Total Assets (a)	7 Admitted Restricted to Total Admitted Assets (b)
a. Subject to contractual obligation for which liability is not shown	$ -	$ -	$ -	$ -	$ -	- %	- %
b. Collateral held under security lending agreements	-	-	-	-	-	-	-
c. Subject to repurchase agreements	-	-	-	-	-	-	-
d. Subject to reverse repurchase agreements	-	-	-	-	-	-	-
e. Subject to dollar repurchase agreements	-	-	-	-	-	-	-
f. Subject to dollar reverse repurchase agreements	-	-	-	-	-	-	-
g. Placed under option contracts	-	-	-	-	-	-	-
h. Letter stock or securities restricted as to sale—excluding FHLB capital stock	-	-	-	-	-	-	-
i. FHLB capital stock	-	-	-	-	-	-	-
j. On deposit with states	912,943	920,834	(7,891)	-	912,943	-	-
k. On deposit with other regulatory bodies	-	-	-	-	-	-	-
l. Pledged as collateral to FHLB (including assets backing funding agreements)	-	-	-	-	-	-	-
m. Pledged as collateral not captured in other categories	-	-	-	-	-	-	-
n. Other restricted assets	-	-	-	-	-	-	-
o. Total restricted assets	$ 912,943	$ 920,834	$ (7,891)	$ -	$ 912,943	- %	- %

(a) Column 1 divided by Asset Page, Column 1, Line 28
(b) Column 5 divided by Asset Page, Column 3, Line 28

(2–4) The Company has no assets pledged as collateral not captured in other categories and no other restricted assets as of December 31, 2020 or 2019.

M. Working Capital Finance Investments — Not applicable.

N. Offsetting and Netting of Assets and Liabilities

The Company does not have any offsetting or netting of assets and liabilities as it relates to derivatives, repurchase and reverse repurchase agreements, and securities borrowing and securities lending activities.

O. 5GI Securities

The Company does not have any investments with an NAIC designation of 5GI as of December 31, 2020 and 2019.

P. Short Sales — Not applicable.

Q. Prepayment Penalty and Acceleration Fees

The following table illustrates prepayment penalty and acceleration fees as of December 31, 2020:

	General Account
1. Number of CUSIPs	4
2. Aggregate Amount of Investment Income	$ 28,477

R. Reporting Entity's Share of Cash Pool by Asset Type — Not applicable.

6. JOINT VENTURES, PARTNERSHIPS, AND LIMITED LIABILITY COMPANIES

A–B. The Company has no investments in joint ventures, partnerships, or limited liability companies that exceed 10% of admitted assets and did not recognize any impairment write-down for its investments in joint ventures, partnerships, and limited liability companies during the statement periods.

7. INVESTMENT INCOME

A. The Company excludes all investment income due and accrued amounts that are over 90 days past due from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

B. There were no investment income amounts excluded from the statutory basis financial statements.

8. DERIVATIVE INSTRUMENTS

A–B. The Company has no derivative instruments.

9. INCOME TAXES

A. Deferred Tax Asset/Liability

(1) The components of the net deferred tax asset at December 31, 2020 and 2019 are as follows:

	2020			2019			Change		
	1 Ordinary	2 Capital	3 (Col 1+2) Total	4 Ordinary	5 Capital	6 (Col 4+5) Total	7 (Col 1 - 4) Ordinary	8 (Col 2 - 5) Capital	9 (Col 7+8) Total
(a) Gross deferred tax assets	$ 1,809,951	$ -	$ 1,809,951	$ 2,513,941	$ 5,044	$ 2,518,985	$ (703,990)	$ (5,044)	$ (709,034)
(b) Statutory valuation allowance adjustments	-	-	-	-	-	-	-	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	1,809,951	-	1,809,951	2,513,941	5,044	2,518,985	(703,990)	(5,044)	(709,034)
(d) Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	1,809,951	-	1,809,951	2,513,941	5,044	2,518,985	(703,990)	(5,044)	(709,034)
(f) Deferred tax liabilities	58,779	-	58,779	73,208	5,810	79,018	(14,429)	(5,810)	(20,239)
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	$ 1,751,172	$ -	$ 1,751,172	$ 2,440,733	$ (766)	$ 2,439,967	$ (689,561)	$ 766	$ (688,795)

(2) The components of the adjusted gross deferred tax assets admissibility calculation under SSAP No. 101, *Income Taxes*, are as follows:

	2020			2019			Change		
Admission Calculation Components SSAP No. 101	1 Ordinary	2 Capital	3 (Col 1 + 2) Total	4 Ordinary	5 Capital	6 (Col 4 + 5) Total	7 (Col 1 - 4) Ordinary	8 (Col 2 - 5) Capital	9 (Col 7 + 8) Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 1,809,951	$ -	$ 1,809,951	$ 2,513,941	$ 5,044	$ 2,518,985	$ (703,990)	$ (5,044)	$ (709,034)
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation. (The lesser of 2(b)1 and 2(b)2 below)	-	-	-	-	-	-	-	-	-
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	-	-	-	-	-	-	-	-	-
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	38,201,003	XXX	XXX	30,071,530	XXX	XXX	8,129,473
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	-	-	-	-	-	-	-	-	-
(d) Deferred tax assets admitted as the result of application of SSAP No. 101 Total (2(a) + 2(b) + 2(c))	$ 1,809,951	$ -	$ 1,809,951	$ 2,513,941	$ 5,044	$ 2,518,985	$ (703,990)	$ (5,044)	$ (709,034)

(3) The ratio percentage and adjusted capital and surplus used to determine the recovery period and threshold limitations for the admissibility calculation are presented below:

	2020	2019
(a) Ratio percentage used to determine recovery period and threshold limitation amount	605 %	528 %
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)(2) above	$ 254,673,350	$ 200,476,868

(4) The impact to the gross deferred tax assets balances as a result of tax-planning strategies as of December 31, 2020 and 2019 is presented below:

	2020		2019		Change	
	1	2	3	4	5	6
Impact of Tax-Planning Strategies	Ordinary	Capital	Ordinary	Capital	(Col 1 - 3) Ordinary	(Col 2 - 4) Capital
(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets by tax character as a percentage.						
1. Adjusted gross DTAs amount from Note 9A1(c)	$ 1,809,951	$ -	$ 2,513,941	$ 5,044	$ (703,990)	$ (5,044)
2. Percentage of adjusted gross DTAs by tax character attributable to the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
3. Net admitted adjusted gross DTAs amount from Note 9A1(e)	$ 1,809,951	$ -	$ 2,513,941	$ 5,044	$ (703,990)	$ (5,044)
4. Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax-planning strategies	- %	- %	- %	- %	- %	- %
(b) Does the Company's tax-planning strategies include the use of reinsurance?			Yes		No X	

B. Unrecognized Deferred Tax Liabilities

(1–4) There are no unrecognized deferred tax liabilities for the years ended December 31, 2020 and 2019.

C. Significant Components of Income Taxes

(1) The current federal and foreign income taxes incurred for the years ended December 31, 2020 and 2019 are as follows:

	1	2	3
	2020	2019	(Col 1 - 2) Change
1. Current income tax			
(a) Federal	$ 34,356,191	$ 9,925,607	$ 24,430,584
(b) Foreign	-	-	-
(c) Subtotal	34,356,191	9,925,607	24,430,584
(d) Federal income tax on net capital (losses) gains	(6,451)	70,581	(77,032)
(e) Utilization of capital loss carryforwards	-	-	-
(f) Other	-	-	-
(g) Total federal and foreign income taxes incurred	$ 34,349,740	$ 9,996,188	$ 24,353,552

(2–4) The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities as of December 31, 2020 and 2019, are as follows:

	1 2020	2 2019	3 (Col 1 - 2) Change
2 Deferred tax assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$ 409,316	$ 362,143	$ 47,173
(2) Unearned premium reserve	17	457	(440)
(3) Policyholder reserves	-	241,710	(241,710)
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	-	-	-
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables — nonadmitted	1,400,618	1,909,631	(509,013)
(11) Net operating loss carryforw ard	-	-	-
(12) Tax credit carryforw ard	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	-	-	-
(99) Subtotal	1,809,951	2,513,941	(703,990)
(b) Statutory valuation allow ance adjustment	-	-	-
(c) Nonadmitted	-	-	-
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	1,809,951	2,513,941	(703,990)
(e) Capital:			
(1) Investments	-	-	-
(2) Net capital loss carryforw ard	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	-	5,044	(5,044)
(99) Subtotal	-	5,044	(5,044)
(f) Statutory valuation allow ance adjustment	-	-	-
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	-	5,044	(5,044)
(i) Admitted deferred tax assets (2d + 2h)	1,809,951	2,518,985	(709,034)
3 Deferred tax liabilities:			
(a) Ordinary:			
(1) Investments	-	2,674	(2,674)
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	58,779	70,534	(11,755)
(99) Subtotal	58,779	73,208	(14,429)
(b) Capital:			
(1) Investments	-	766	(766)
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	-	5,044	(5,044)
(99) Subtotal	-	5,810	(5,810)
(c) Deferred tax liabilities (3a99 + 3b99)	58,779	79,018	(20,239)
4 Net deferred tax assets/liabilities (2i - 3c)	$ 1,751,172	$ 2,439,967	$ (688,795)

The other capital deferred tax asset of $5,044 for 2019 consists of unrealized gains. The other ordinary deferred tax liability of $58,779 and $70,534 for 2020 and 2019, respectively, consists of discounting unpaid losses. The other capital deferred tax liability of $5,044 for 2019 consists of unrealized losses.

The Company assessed the potential realization of the gross deferred tax asset and as a result no statutory valuation allowance was required and no allowance was established as of December 31, 2020 and 2019.

D. The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate of 21% to net income before federal income taxes incurred, less capital gains tax benefit (losses). A summarization of the significant items causing this difference as of December 31, 2020 and 2019 is as follows:

	2020		2019	
	Amount	Effective Tax Rate	Amount	Effective Tax Rate
Tax provision at the federal statutory rate	$ 27,157,817	21 %	$ 8,957,262	21 %
Tax-exempt interest	(52,424)	-	(58,553)	-
Health insurer fee	7,259,148	6	-	-
Other current year items	165,106	-	736,328	1
Tax effect of nonadmitted assets	508,888	-	1,222,716	3
Change in statutory valuation allowance	-	-	(4,172)	-
Total statutory income taxes	$ 35,038,535	27 %	$ 10,853,581	25 %
Federal income taxes incurred	$ 34,356,191	26 %	$ 9,925,607	23 %
Capital gains (benefit) tax	(6,451)	-	70,581	-
Change in net deferred income tax	688,795	1	857,393	2
Total statutory income taxes	$ 35,038,535	27 %	$ 10,853,581	25 %

E. At December 31, 2020, the Company had no net operating loss carryforwards.

Current federal income tax recoverable (payable) of $1,594,260 and ($5,921,188) as of December 31, 2020 and 2019, respectively, are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Federal income taxes paid, net of refunds were $41,865,188 and $7,360,276 in 2020 and 2019, respectively.

Federal income taxes incurred of $34,349,740 and $9,996,188 for 2020 and 2019, respectively, are available for recoupment in the event of future net losses.

The Company has not admitted any aggregate amounts of deposits that are included within Section 6603 (“Deposits made to suspend running of interest on potential underpayments, etc.”) of the Internal Revenue Service (“IRS”) Code.

F. The Company is included in the consolidated federal income tax return with its ultimate parent, UnitedHealth Group. The entities included within the consolidated return are included in the NAIC Statutory Statement Schedule Y - Information Concerning Activities of Insurer Members Of A Holding Company Group. Federal income taxes are paid to or refunded by UnitedHealth Group pursuant to the terms of a tax-sharing agreement, approved by the Board of Directors, under which taxes approximate the amount that would have been computed on a separate company basis, with the exception of net operating losses and capital losses. For these losses the Company receives a benefit at the federal rate in the current year for current taxable losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UnitedHealth Group. UnitedHealth Group currently files income tax returns in the U.S. federal jurisdiction, various states, and foreign jurisdictions. The U.S. IRS has completed exams on UnitedHealth Group’s consolidated income tax returns for fiscal years 2016 and prior. UnitedHealth Group’s 2017 through 2020 tax returns are under review by the IRS under its

Compliance Assurance Program. With the exception of a few states, UnitedHealth Group is no longer subject to income tax examinations prior to the 2013 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2015 and forward. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

G. Tax Contingencies — Not applicable.

H. Repatriation Transition Tax — Not applicable.

I. Alternative Minimum Tax Credit — Not applicable.

10. INFORMATION CONCERNING PARENT, SUBSIDIARIES, AND AFFILIATES

A–B. In the ordinary course of business, the Company contracts with several affiliates to provide a wide variety of services to the Company's members. These agreements are filed with and approved by the Department according to Management's understanding of the current requirements and standards. Within the confines of the applicable filed and approved agreements (including subsequent amendments thereto), the amount and types of services provided by these affiliated entities can change year over year.

The Company has a tax-sharing agreement with UnitedHealth Group (see Note 9).

The Company paid dividends of $43,200,000 and $25,000,000 in 2020 and 2019, respectively, to its parent (see Note 13).

The Company holds a $40,000,000 subordinated revolving credit agreement with UnitedHealth Group at an interest rate of London InterBank Offered Rate plus a margin of 0.50%. This credit agreement is subordinate to the extent it does not conflict with any credit facility held by either party. This agreement shall be effective as of the effective date and shall continue until terminated pursuant to the terms of this agreement which requires either party to give a 60 day written notice to the other party. No amounts were outstanding under the line of credit as of December 31, 2020 and 2019. No amount of interest was paid or still accrued on all borrowings throughout the years of December 31, 2020 and 2019, respectively.

The Company has entered into reinsurance agreements with affiliated entities (see Note 23).

C. Transactions With Related Parties Who Are Not Reported On Schedule Y

The Company has no material related party transactions that meet the disclosure requirements pursuant to SSAP No. 25, *Affiliates and Other Related Parties* ("SSAP No. 25") that are not included in NAIC Statutory Statement Schedule Y — Part 2 Summary Of Insurer's Transactions With Any Affiliates.

D. At December 31, 2020 and 2019, the Company reported $18,178,607 as amounts due to parent, subsidiaries, and affiliates, net and $1,005,834 as receivables from parent, subsidiaries and affiliates, net, respectively, which are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. These balances are generally settled within 90 days from the incurred date. Any balances due to the Company that are not settled within 90 days are considered nonadmitted assets.

E. The administrative services, access fees, and cost of care services provided by affiliates are calculated using one or more of the following methods: (1) a percentage of premiums; (2) use of assets; (3) direct pass-through of charges; (4) PMPM; (5) per employee per month; (6) per claim; or (7) a combination thereof consistent with the provisions contained in each contract. These

amounts are included in GAE, CAE, and hospital and medical expenses in the statutory basis statements of operations. The following table identifies the amounts reported for the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2020 and 2019, which meet the disclosure requirements pursuant to SSAP No. 25, regardless of the effective date of the contract:

	2020	2019
OptumRx	$ 221,538,303	$ 174,385,250
United HealthCare Services, Inc.	193,499,220	179,559,070
United Behavioral Health	148,615,379	127,552,968
OptumInsight, Inc.	9,486,917	3,694,494
Dental Benefit Providers, Inc.	3,915,415	3,656,090
AxelaCare Intermediate Holdings, LLC	-	2,673,844

OptumRx provides services that may include, but are not limited to, administrative services related to pharmacy management and pharmacy claims processing for enrollees, manufacturer rebate administration, pharmacy incentive services, specialty drug pharmacy services, durable medical equipment services including orthotics and prosthetics and personal health products catalogues showing the healthcare products and benefit credits enrollees needed to redeem the respective products.

UHS provides, or arranges for the provision of, management, administrative, and other services deemed necessary or appropriate for UHS to provide management and operational support to the Company. The services can include, but are not limited to, the categories of management and operational services outlined in the Agreement, such as human resources, legal, facilities, general administration, treasury and investment functions, claims adjudication and payment, benefit administration, disease management, health care decision support, medical management, credentialing, preventative health services, and utilization management reporting.

United Behavioral Health provides services related to mental health and substance abuse treatment.

OptumInsight, Inc. provides services that may include, but are not limited to, claim analytics and recovery of medical expense overpayments, retroactive fraud, waste and abuse, subrogation and premium audit services. All recoveries are returned to the Company by OptumInsight, Inc. on a monthly basis.

Dental Benefit Providers, Inc. provides dental care assistance.

AxelaCare Intermediate Holdings, LLC provides home infusion therapy services.

The Company has premium payments that are received and claim payments that are processed and paid by an affiliated UnitedHealth Group entity. Premiums and claims applicable to the Company are settled at regular intervals throughout the month via the intercompany settlement process and any amounts outstanding are reflected in receivables from parent, subsidiaries, and affiliates, net and amounts due to parent, subsidiaries, and affiliates, net in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company’s affiliate, UHS, provides a guarantee to the KDHE to perform the Company’s obligations and discharge its liabilities under the Medicaid contract should the Company fail to perform. The parent will also indemnify and hold harmless the KDHE against any and all losses, damages, claims, costs, charges and expenses under the terms of the contract.

F. The Company has not extended any guarantees or undertakings for the benefit of an affiliate or related party.

G. The Company is part of an insurance holding company system with UnitedHealth Group as the ultimate parent. Management believes that the Company's transactions with affiliates are fair and reasonable; however, operations of the Company may not be indicative of those that would have occurred if it had operated as an independent company.

H. The Company does not have any amount deducted from the value of an upstream intermediate entity or ultimate parent owned, either directly or indirectly, via a downstream subsidiary, controlled, or affiliated entity.

I. The Company does not have any investments in a subsidiary, controlled, or affiliated entity that exceeds 10% of admitted assets.

J. The Company does not have any investments in impaired subsidiaries, controlled, or affiliated entities.

K. The Company does not have any investments in foreign insurance subsidiaries.

L. The Company does not hold any investments in a downstream noninsurance holding company.

M. The Company does not have any investments in noninsurance subsidiaries, controlled, or affiliated entities.

N. The Company does not have any investments in insurance subsidiaries, controlled, or affiliated entities.

O. The Company does not have any investments in subsidiary, controlled, or affiliated entities or joint ventures, partnerships and limited liability companies in which the Company's share of losses exceeds the investment.

11. DEBT

A–B. The Company had no outstanding debt with third-parties or outstanding Federal Home Loan Bank agreements during 2020 and 2019.

12. RETIREMENT PLANS, DEFERRED COMPENSATION, POSTEMPLOYMENT BENEFITS AND COMPENSATED ABSENCES AND OTHER POSTRETIREMENT BENEFIT PLANS

A–I. The Company has no defined benefit plans, defined contribution plans, multiemployer plans, consolidated/holding company plans, postemployment benefits, or compensated absences plans and is not impacted by the Medicare Modernization Act on postretirement benefits, since all personnel are employees of UHS, which provides services to the Company under the terms of the Agreement (see Note 10).

13. CAPITAL AND SURPLUS, DIVIDEND RESTRICTIONS, AND QUASI-REORGANIZATIONS

A–B. The Company has 100 shares authorized and 1 share issued and outstanding of $1 par value common stock. The Company has no preferred stock outstanding. All issued and outstanding shares of common stock are held by the Company's parent, UHC.

C. Dividend payment requirements are outlined in the domiciliary state statutes and may be further restricted by the Department.

D. The Company paid an ordinary cash dividend to UHC of $3,200,000 on June 5, 2020, which required no approval and was recorded as a reduction to unassigned surplus in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company paid extraordinary cash dividends to UHC of $20,000,000 on September 21, 2020 and December 21, 2020, which were approved by the Department and recorded as a reduction to unassigned surplus in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company paid an extraordinary cash dividend to UHC of $25,000,000 on June 4, 2019, which was approved by the Department and recorded as a reduction to unassigned surplus in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

E. The amount of ordinary dividends that may be paid out during any given period is subject to certain restrictions as specified by state statute.

F. There are no restrictions placed on the Company's unassigned surplus.

G. The Company is not a mutual reciprocal or a similarly organized entity and does not have advances to surplus not repaid.

H. The Company does not hold any stock, including stock of affiliated companies for special purposes, such as conversion of preferred stock, employee stock options, or stock purchase warrants.

I. As discussed in Note 1, in 2020 no amount was required to be apportioned out of unassigned surplus as the HIF was repealed by Congress, effective January 1, 2021. For the year ended December 31, 2019, the amount of the estimated Section 9010 ACA subsequent fee year assessment apportioned out of unassigned surplus was $34,403,481.

J. The portion of unassigned surplus, excluding the apportionment of estimated Section 9010 ACA subsequent fee year assessment, net income, and dividends, represented (or reduced) by each item below is as follows:

	2020	2019
Net deferred income taxes	1,751,172	2,439,967
Nonadmitted assets	(6,670,203)	(9,093,481)
Total	$ (4,919,031)	$ (6,653,514)

K–M. The Company does not have any outstanding surplus notes and has never been a party to a quasi-reorganization.

14. LIABILITIES, CONTINGENCIES AND ASSESSMENTS

A. Contingent Commitments

The Company has no contingent commitments.

B. Assessments

The Company is not aware of any guaranty fund assessments or premium tax offsets, potential or accrued, that could have a material financial effect on the operations of the entity.

C. Gain Contingencies

The Company is not aware of any gain contingencies that should be disclosed in the statutory basis financial statements.

D. Claims Related Extra Contractual Obligation and Bad Faith Losses Stemming from Lawsuits — Not applicable.

E. Joint and Several Liabilities — Not applicable.

F. All Other Contingencies

The Company's business is regulated at the federal, state, and local levels. The laws and rules governing the Company's business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Further, the Company must obtain and maintain regulatory approvals to market and sell many of its products.

The Company has been, or is currently involved, in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments and other governmental authorities. The Company cannot reasonably estimate the range of loss, if any, that may result from any material government investigations, audits and reviews in which it is currently involved given the inherent difficulty in predicting regulatory action, fines and penalties, if any, and the various remedies and levels of judicial review available to the Company in the event of an adverse finding.

On February 14, 2017, the Department of Justice ("DOJ") announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges that the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, the DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters involve: indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility, or it is probable that a loss may be incurred. Although the outcomes of any such legal actions cannot be predicted, in the opinion of management, the resolution of any currently pending or threatened actions will not have a

material adverse effect on the statutory basis statements of admitted assets, liabilities, and capital and surplus or statutory basis statements of operations of the Company.

The Company routinely evaluates the collectability of all receivable amounts included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Impairment reserves are established for those amounts where collectability is uncertain. Based on the Company's past experience, exposure related to uncollectible balances and the potential of loss for those balances not currently reserved for is not material to the Company's statutory basis financial condition.

There are no assets that the Company considers to be impaired at December 31, 2020 and 2019, except as disclosed in Note 1 and Note 5.

15. LEASES

A–B. According to the Agreement between the Company and UHS (see Note 10), operating leases for the rental of office facilities and equipment are the responsibility of UHS. Fees associated with the lease agreements are included as a component of the Company's management fee.

16. INFORMATION ABOUT FINANCIAL INSTRUMENTS WITH OFF-BALANCE-SHEET RISK AND FINANCIAL INSTRUMENTS WITH CONCENTRATIONS OF CREDIT RISK

(1–4) The Company does not hold any financial instruments with off-balance-sheet risk or have any concentrations of credit risk.

17. SALE, TRANSFER, AND SERVICING OF FINANCIAL ASSETS AND EXTINGUISHMENTS OF LIABILITIES

A–C. The Company did not participate in any transfer of receivables, financial assets or wash sales.

18. GAIN OR LOSS TO THE REPORTING ENTITY FROM UNINSURED PLANS AND THE UNINSURED PORTION OF PARTIALLY INSURED PLANS

A–B. The Company has no operations from Administrative Services Only Contracts or Administrative Services Contracts in 2020 and 2019.

C. Medicare or Other Similarly Structured Cost Based Reimbursement Contract

The Medicare Part D program is a partially insured plan. The Company recorded a receivable of $19,412,230 and $40,899,882 at December 31, 2020 and 2019, respectively, for cost reimbursement under the Medicare Part D program for the catastrophic reinsurance and low-income member cost-sharing subsidies. The Company also recorded a receivable of $1,954 and a payable of $7,360 at December 31, 2020 and 2019, respectively, for the Medicare Part D Coverage gap discount program. The receivables and payables are recorded in amounts receivable relating to uninsured plans and liability for amounts held under uninsured plans, respectively, in the statutory basis statements of admitted assets, liabilities and capital and surplus. These Medicare subsidies are described in Note 1, *Amounts Receivable Relating to Uninsured Plans* and *Liability for Amounts Held Under Uninsured Plans*.

The Company participates in administering the payments for the HealthNet FRA program. There is no risk to the Company as a result of these transactions. The Company has a FRA program payable of $1,767,624 and $1,267,450 as of December 31, 2020 and 2019, respectively, which is included in liability for amounts held for uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

19. DIRECT PREMIUM WRITTEN/PRODUCED BY MANAGING GENERAL AGENTS/THIRD-PARTY ADMINISTRATORS

The Company did not have any direct premiums written or produced by managing general agents or third-party administrators in 2020 and 2019.

20. FAIR VALUE MEASUREMENTS

The NAIC SAP defines fair value, establishes a framework for measuring fair value, and outlines the disclosure requirements related to fair value measurements. The fair value hierarchy is as follows:

Level 1 — Quoted (unadjusted) prices for identical assets in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets in active markets;
- Quoted prices for identical or similar assets in nonactive markets (few transactions, limited information, noncurrent prices, high variability over time, etc.);
- Inputs other than quoted prices that are observable for the asset (interest rates, yield curves, volatilities, default rates, etc.);
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

The estimated fair values of bonds and cash equivalents are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service ("pricing service"), which generally uses quoted prices or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, making adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, non-binding broker quotes, benchmark yields, credit spreads, default rates, and prepayment speeds. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to a secondary pricing source, prices reported by its custodian, its investment consultant, and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and review of fair value methodology documentation provided by independent pricing services have not historically resulted in an adjustment in the prices obtained from the pricing service.

In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement has been determined based on the lowest-level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

A. Fair Value

(1) Fair Value Measurements at Reporting Date

The following tables present information about the Company's financial assets that are measured and reported at fair value at December 31, 2020 and 2019, in the statutory basis statements of admitted assets, liabilities, and capital and surplus according to the valuation techniques the Company used to determine their fair values:

	December 31, 2020				
Description for Each Class of Asset or Liability	**(Level 1)**	**(Level 2)**	**(Level 3)**	**Net Asset Value(N**	**Total**
a. Assets at fair value:					
Perpetual preferred stock:					
Industrial and misc	$ -	$ -	$ -	$ -	$ -
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total perpetual preferred stocks	-	-	-	-	-
Bonds:					
U.S. governments	-	-	-	-	-
Industrial and misc	-	-	-	-	-
Hybrid securities	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total bonds	-	-	-	-	-
Common stock:					
Industrial and misc	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stocks	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forw ard contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	128,441,832	-	-	-	128,441,832
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 128,441,832	$ -	$ -	$ -	$ 128,441,832
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

Description for Each Class of Asset or Liability	December 31, 2019 (Level 1)	(Level 2)	(Level 3)	Asset Value(N	Total
a. Assets at fair value:					
Perpetual preferred stock:					
Industrial and misc	$ -	$ -	$ -	$ -	$ -
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total perpetual preferred stocks	-	-	-	-	-
Bonds:					
U.S. governments	-	-	-	-	-
Industrial and misc	-	-	-	-	-
Hybrid securities	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total bonds	-	-	-	-	-
Common stock:					
Industrial and misc	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stocks	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forw ard contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	68,685,650	-	-	-	68,685,650
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 68,685,650	$ -	$ -	$ -	$ 68,685,650
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

(2) The Company does not have any financial assets with a fair value hierarchy of Level 3 that were measured and reported at fair value.

(3) Transfers between fair value hierarchy levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs. There were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during the years ended December 31, 2020 or 2019.

(4) The Company has no investments reported with a fair value hierarchy of Level 2 or Level 3 and therefore has no valuation technique to disclose.

(5) The Company has no derivative assets and liabilities to disclose.

B. Fair Value Combination — Not applicable.

C. Aggregate Fair Value Hierarchy

The aggregate fair value by hierarchy of all financial instruments as of December 31, 2020 and 2019 is presented in the table below:

	December 31, 2020						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 13,979,034	$ 13,209,165	$ 5,073,985	$ 8,905,049	$ -	$ -	$ -
State and agency municipal securities	5,626,199	5,169,379	-	5,626,199	-	-	-
City and county municipal securities	9,541,125	8,913,636	-	9,541,125	-	-	-
Corporate debt securities	26,263,326	24,769,739	-	26,263,326	-	-	-
Cash equivalents	128,441,832	128,441,832	128,441,832	-	-	-	-
Total bonds and cash equivalents	$ 183,851,516	$ 180,503,751	$ 133,515,817	$ 50,335,699	$ -	$ -	$ -

	December 31, 2019						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 14,079,060	$ 13,733,695	$ 4,801,451	$ 9,277,609	$ -	$ -	$ -
State and agency municipal securities	5,528,594	5,232,927	-	5,528,594	-	-	-
City and county municipal securities	8,469,626	8,069,280	-	8,469,626	-	-	-
Corporate debt securities	24,588,200	23,883,867	-	24,588,200	-	-	-
Cash equivalents	68,865,650	68,865,650	68,865,650	-	-	-	-
Total bonds and cash equivalents	$ 121,531,130	$ 119,785,419	$ 73,667,101	$ 47,864,029	$ -	$ -	$ -

D. Not Practicable to Estimate Fair Value — Not applicable.

E. Investments Measured Using the NAV Practical Expedient — Not applicable.

21. OTHER ITEMS

COVID-19 Trends and Uncertainties

The COVID-19 pandemic continues to evolve and the ultimate impact on the Company and its statutory basis results of operations, financial condition and cash flows remains uncertain. During the second quarter, the global health system experienced unprecedented levels of care deferral. As the pandemic advanced, access to and demand for care was most constrained from mid-March through April, began to recover in May and June and restored to near normal seasonal levels in the third quarter. Care patterns continued to normalize in the fourth quarter, including COVID-19 treatment and testing costs. The temporary deferral of care experienced in 2020 may cause care patterns to moderately exceed normal baselines in future periods as utilization of health system capacity continues to increase. The Company has taken various measures which could include expanded benefit coverage in areas such as COVID-19 care and testing, telemedicine, and pharmacy benefits; provided customers assistance in the form of co-pay waivers and premium forgiveness; offered additional enrollment opportunities to those who previously declined employer-sponsored offerings; extended certain premium payment terms for customers experiencing financial hardship; simplified administrative practices; and accelerated payments to care providers, all with the aim of assisting customers, care providers, members and communities in addressing the COVID-19 crisis. Temporary care deferrals impacted the Company's results of operations for the year ended December 31, 2020. The impact of temporary care deferrals was partially offset by COVID-19 related care and testing, the financial assistance provided to customers, rebate requirements and broader economic impacts.

Increased consumer demand for care, potentially even higher acuity care, along with continued COVID-19 care and testing costs may result in increased future medical costs. Disrupted care patterns, as a result of the pandemic, may temporarily affect the ability to obtain complete member health status information, impacting future revenue in businesses utilizing risk adjustment methodologies. The ultimate overall impact is uncertain and dependent on the future pacing and intensity of the pandemic, the duration of policies and initiatives to address COVID-19, and general economic uncertainty.

Throughout 2020, the Company's ultimate parent announced a number of programs to directly support people affected by the COVID-19 pandemic, including a plan to grant premium credits to the Company's fully insured commercial customers. The total amount of premium credits granted through December 31, 2020 of $97 has been reflected as a reduction to net premium income in the statutory basis statements of operations.

A. Unusual or Infrequent Items

The Company did not encounter any unusual or infrequent items for the years ended December 31, 2020 and 2019.

B. Troubled Debt Restructuring: Debtors

The Company has no troubled debt restructurings as of December 31, 2020 and 2019.

C. Other Disclosures

The Company does not have any amounts not recorded in the statutory basis financial statements that represent segregated funds held for others. The Company also does not have any exposures related to forward commitments that are not derivative instruments.

D. Business Interruption Insurance Recoveries

The Company has not received any business interruption insurance recoveries during 2020 and 2019.

E. State Transferable and Non-transferable Tax Credits

The Company has no transferable or non-transferable state tax credits.

F. Sub-Prime Mortgage-Related Risk Exposure

(1) The investment policy for the Company limits investments in loan-backed securities, which includes sub-prime issuers. Further, the policy limits investments in private-issuer mortgage securities to 10% of the portfolio, which also includes sub-prime issuers. The exposure to unrealized losses on sub-prime issuers is due to changes in market prices. There are no realized losses due to not receiving anticipated cash flows. The investments covered have an NAIC designation of 1 or 2.

(2) The Company has no direct exposure through investments in sub-prime mortgage loans.

(3) The Company has no direct exposure through other investments.

(4) The Company has no underwriting exposure to sub-prime mortgage risk through mortgage guaranty or financial guaranty insurance coverage.

G. Retained Assets

The Company does not have any retained asset accounts for beneficiaries.

H. Insurance-Linked Securities Contracts

As of December 31, 2020, the Company is not aware of any possible proceeds of insurance-linked securities.

I. **The Amount That Could Be Realized on Life Insurance Where the Reporting Entity is Owner and Beneficiary or Has Otherwise Obtained Rights to Control the Policy** — Not applicable.

22. EVENTS SUBSEQUENT

Subsequent events have been evaluated through April 23, 2021, which is the date these statutory basis financial statements were available for issuance.

TYPE I — Recognized Subsequent Events

Any material Type I events subsequent to December 31, 2020, have been recognized in the statutory basis financial statements and corresponding disclosures.

TYPE II — Non-Recognized Subsequent Events

For the years ended December 31, 2020 and 2019, the Company was subject to the annual fee under Section 9010 of the ACA. The fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of the health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1, of the year the fee is due. The HIF was repealed by Congress, effective January 1, 2021.

The table below presents information regarding the annual fee under Section 9010 of the ACA as of December 31, 2020 and 2019:

	2020	2019
A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (YES/NO)?	YES	
B. ACA fee assessment payable for the upcoming year	$ -	$ 34,403,481
C. ACA fee assessment paid	34,567,370	-
D. Premium written subject to ACA 9010 assessment	-	1,803,551,009
E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)	256,424,522	
F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus 22B above)	256,424,522	
G. Authorized Control Level (Five-Year Historical Line 15)	42,067,968	
H. Would reporting the ACA assessment as of December 31, 2020, have triggered an RBC action level (YES/NO)?	NO	

There are no other material non-recognized Type II events that require disclosure.

23. REINSURANCE

Reinsurance Agreements — In the normal course of business, the Company seeks to reduce potential losses that may arise from catastrophic events that cause unfavorable underwriting results by reinsuring certain levels of such risk with affiliated and other nonaffiliated reinsurers. The Company remains primarily liable as the direct insurer on all risks reinsured.

The Company has a reinsurance agreement with UHIC, an affiliate of the Company, through which 60% of earned comprehensive commercial and Medicaid member premiums, hospital and medical expenses, and operating expenses are transferred to UHIC. The Company transferred premiums of $1,238,838,278 and $1,088,913,549, and GAE and CAE of $152,282,578 and $134,388,830 in 2020 and 2019, respectively, to UHIC under this agreement. The Company recorded receivables related to changes in reserve estimates of $85,628,940 and $81,192,159 in 2020 and 2019, respectively, which are netted against claims unpaid and aggregate health claim reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company recorded reinsurance receivables of $8,262,278 related to the new KDHE risk corridor reserves, which is netted against aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2020. The Company recognized reinsurance recoveries of $994,673,161 and $963,619,539 in 2020 and 2019, respectively, which are recorded as net reinsurance recoveries in the statutory basis statements of operations. The Company recorded ceded reserves for provider incentives of $1,750,058 and $2,096,031 in 2020 and 2019, respectively, which is included in accrued medical incentive pool and bonus amounts in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company recorded paid claims receivables related to this agreement, including payments made for the medical loss ratio rebates, of $89,645,722 and $68,152,757 in 2020 and 2019, respectively, which are included in amounts recoverable from reinsurers in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company recorded a receivable related to GAE and CAE of $15,418,689 and $14,405,462 in 2020 and 2019, respectively, which is included in other amounts receivable under reinsurance contracts in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company recorded a payable to UHIC for premiums ceded of $106,736,460 and $91,483,742 as of December 31, 2020 and 2019, respectively, which are included in ceded reinsurance premiums payable in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The agreement also provides insolvency-only protection for its enrollees. Fees related to this agreement, which are calculated based on a percentage of earned premiums, of $2,810,638 and $2,325,510 in 2020 and 2019, respectively, are netted against net premium income in the statutory basis statements of operations. The Company recorded a payable to UHIC for premiums ceded related to the insolvency agreement of $218,941 and $200,143 in 2020 and 2019, respectively, which are included in ceded reinsurance premiums payable in the statutory basis statements of admitted assets, liabilities, and capital and surplus. This agreement also provides for reserve cap protection. Reinsurance contracts do not relieve the Company from its obligations to policyholders. Failure of reinsurers to honor their obligations could result in losses to the Company.

Pursuant to Section 1341 of the ACA, through 2017, the Company was subject to the reinsurance provisions for compliant individual policies (see Note 24).

The effect of both internal and external reinsurance agreements outlined above on net premium income, hospital and medical expenses, GAE, and CAE is presented below:

	2020	2019
Premiums:		
Direct	$ 2,816,853,893	$ 2,331,152,493
Ceded:		
Affiliate	1,241,648,916	1,091,239,058
Nonaffiliate	-	-
Net premium income	$ 1,575,204,977	$ 1,239,913,435
Change in reserve for rate credits:		
Direct	$ (10,443,076)	$ (7,530,986)
Ceded:		
Affiliate	8,262,278	-
Nonaffiliate	-	-
Net change in reserve for rate credits	$ (2,180,798)	$ (7,530,986)
Hospital and medical expenses:		
Direct	$ 2,244,465,494	$ 2,008,099,444
Ceded:		
Affiliate	994,673,161	963,619,539
Nonaffiliate	-	16,941
Net hospital and medical expenses	$ 1,249,792,333	$ 1,044,462,964
General administrative expenses and claims adjustment expenses:		
Direct	$ 347,857,433	$ 278,621,087
Ceded:		
Affiliate	152,282,578	134,388,830
Nonaffiliate	-	-
Net general administrative expenses and claims adjustment expenses	$ 195,574,855	$ 144,232,257

A. Ceded Reinsurance Report

Section 1 — General Interrogatories

(1) Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes ( ) No (X)

(2) Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor, or any other person not primarily engaged in the insurance business?

Yes ( ) No (X)

Section 2 — Ceded Reinsurance Report — Part A

(1) Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credit?

Yes ( ) No (X)

(2) Does the reporting entity have any reinsurance agreements in effect that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

Yes ( ) No (X)

Section 3 — Ceded Reinsurance Report — Part B

(1) What is the estimated amount of the aggregate reduction in surplus (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of all reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

The Company estimates there should be no aggregate reduction in surplus for termination of all reinsurance agreements as of December 31, 2020.

(2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes ( ) No (X)

B. **Uncollectible Reinsurance** — During 2020 and 2019, there were no uncollectible reinsurance recoverables.

C. **Commutation of Ceded Reinsurance** — There was no commutation of reinsurance in 2020 or 2019.

D. **Certified Reinsurer Rating Downgraded or Status Subject to Revocation** — Not applicable.

E. **Reinsurance Credit**

(1) The Company has no reinsurance contracts subject to Appendix A-791—*Life and Health Reinsurance Agreements* (“A-791”) that includes a provision which limits the reinsurer’s assumption of significant risk.

(2) The Company has no reinsurance contracts not subject to A-791, for which reinsurance accounting was applied and which include a provision that limits the reinsurer’s assumption of risk.

(3) The Company’s reinsurance contracts do not contain features which result in delays in payment in form or in fact.

(4) The Company has not reflected a reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk transfer requirements of SSAP No. 61R, Life, Deposit-Type, and Accident and Health Reinsurance ("SSAP No. 61R").

(5) The Company did not cede any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract during the period covered by these financial statements, for which the statutory accounting treatment and GAAP accounting treatment were not the same.

(6) The Company's ceded reinsurance contract which is not subject to A-791 and not yearly renewable term reinsurance, is treated the same for GAAP and statutory accounting principles.

24. RETROSPECTIVELY RATED CONTRACTS AND CONTRACTS SUBJECT TO REDETERMINATION

A. The Company estimates accrued retrospective premium adjustments for its group health insurance business based on mathematical calculations in accordance with contractual terms.

B. Estimated accrued retrospective premiums due to (from) the Company are recorded in premiums and considerations and aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as an adjustment to change in reserve for rate credits in the statutory basis statements of operations.

C. Pursuant to the ACA, the Company's commercial business is subject to retrospectively rated features based on the actual medical loss ratios experienced on the commercial lines of business and redetermination features for premium adjustments for changes to each member's health scores based on guidelines determined by ACA. The total amount of direct premiums written for the commercial lines of business for which a portion is subject to the retrospectively rated and redetermination features was $394,779 and $20,051, representing less than 1% of total direct premiums written as of December 31, 2020 and 2019, respectively.

Pursuant to the ACA, the Company's Medicare business is subject to retrospectively rated features based on the actual medical loss ratios experienced on the Medicare line of business and redetermination features for premium adjustments for changes to each member's health scores based on guidelines determined by CMS. The formula is calculated pursuant to the ACA guidance. The total amount of direct premiums written for the Medicare line of business for which a portion is subject to the retrospectively rated and redetermination features was $755,982,588 and $519,767,940, representing 27% and 22% of total direct premiums written as of December 31, 2020 and 2019, respectively.

The Company has Medicare Part D risk-corridor amounts from CMS which are subject to a retrospectively rated feature related to Part D premiums. The Company has estimated accrued retrospective premiums related to certain Part D premiums based on guidelines determined by CMS. The formula is tiered and based on the bid medical loss ratio. The amount of Medicare Part D direct premiums written subject to the retrospectively rated feature was $33,607,887 and $27,453,497, representing 1% of total direct premiums written for 2020 and 2019, respectively.

The Company's KanCare program is subject to retrospectively rated features based on the actual medical loss ratio experiences on the Medicaid line of business. The formula is calculated pursuant to the terms outlined in the KanCare contract. The total amount of direct premiums written from the Medicaid contract for which a portion is subject to the retrospectively rated features was $1,429,463,408 and $1,303,121,493, representing 51% and 56% of total direct premiums written as of December 31, 2020 and 2019, respectively.

The KanCare contract, including CHIP, with the State of Kansas includes a provision for which a stated percentage of total direct premiums written can be eligible for a performance guarantee payment, based on various quality measures. The total amount of direct premiums written from the Medicaid contract, including CHIP, for which a portion is subject to the redetermination feature was $42,931,490 and $39,330,036, representing 2%, of the Company's total direct premiums written, as of December 31, 2020 and 2019, respectively.

The Company's HealthNet Program is subject to retrospectively rated features based on actual medical loss ratio experiences on the Medicaid line of business. The formula is calculated pursuant to the terms outlined in the HealthNet contract. The total amount of direct premiums written from the Medicaid contract for which a portion is subject to the retrospectively rated feature was $631,013,118 and $508,243,010, representing 22% and 22%, of the Company's total direct premiums written, as of December 31, 2020 and 2019, respectively.

The HealthNet contract, including CHIP, with the State of Missouri includes a provision for which a stated percentage of total direct premiums written can be eligible for a performance guarantee payment, based on various quality measures. The total amount of direct premiums written from the Medicaid contract, including CHIP, for which a portion is subject to the redetermination feature was $16,300,510 and $16,368,331, representing 1% of the Company's total direct premiums written, as of December 31, 2020 and 2019, respectively.

Effective January 1, 2020, KDHE implemented a risk corridor program into the Company's KDHE Medicaid and CHIP contract. The Company has estimated accrued retrospective premiums based on guidelines determined by the KDHE. The formula is tiered and based on a targeted minimum loss ratio based on guidelines determined by the KDHE. The formula is tiered and based on a baseline benefit expense. The amount of direct premiums written for the KDHE Medicaid and CHIP business, for which a portion is subject to the retrospectively rated feature, was $1,411,114,698 representing 50% of the Company's total direct premiums written as of December 31, 2020.

D. The Company is required to maintain specific minimum loss ratios on the comprehensive commercial and Medicare lines of business.

The following table discloses the minimum medical loss ratio rebate liability for the Medicare line of business which is included in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus for the years ended December 31, 2020 and 2019:

	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Other Categories with Rebates	5 Total
Prior reporting year					
(1) Medical loss ratio rebates incurred	$ -	$ -	$ -	$ 728,000	$ 728,000
(2) Medical loss ratio rebates paid	-	-	-	5,101,780	5,101,780
(3) Medical loss rebates unpaid	-	-	-	9,111,698	9,111,698
(4) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(5) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(6) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	9,111,698
Current reporting year-to-date					
(7) Medical loss ratio rebates incurred	-	-	-	6,091,505	6,091,505
(8) Medical loss ratio rebates paid	-	-	-	6,870,288	6,870,288
(9) Medical loss rebates unpaid	-	-	-	8,332,915	8,332,915
(10) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(11) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(12) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	8,332,915

Pursuant to the Medicaid Managed Care Rule, based on the State's election and state contractual minimum loss ratio requirements, the Company is required to maintain specific minimum loss ratios on its HealthNet and KanCare populations. The Company's actual medical loss ratios for the Medicaid Managed Care Rule and state contractual requirements were in excess of the minimum requirements and as a result, no minimum loss ratio liability was required as of December 31, 2020 and December 31, 2019, respectively.

E. Risk-Sharing Provisions of the Affordable Care Act

(1) The Company has accident and health insurance premiums in 2020 and 2019 subject to the risk-sharing provisions of the ACA.

The ACA imposed fees and premium stabilization provisions on health insurance issuers offering comprehensive commercial health insurance. The three premium stabilization programs are commonly referred to as the 3Rs — risk adjustment, reinsurance, and risk corridors.

Risk Adjustment — The permanent risk adjustment program, designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers, applies to all non-grandfathered plans not subject to transitional relief in the individual and small group markets both inside and outside of the insurance exchanges. The risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. The operation of the high-cost risk pools excludes a percentage of costs above a threshold level determined by federal regulations. The program operates two national high-cost risk pools, one for individuals and one for small groups. The data used by CMS to determine the risk adjustment amount is subject to risk adjustment data validation audits along with the true-up to the final CMS report, which may result in a material change to arrive at the final risk adjustment amount from the initial risk adjustment estimate recorded. The risk adjustment data validation audits for 2017 and 2018 have been finalized and any adjustment from the estimate recorded is included in net premium income in the statutory basis financial statements in the period in which the amount became known. The remaining audits for the open years have not been completed. Estimates related to the open years have incorporated CMS' Final Rule on Amendments to the U.S. Department of Health & Human Services ("HHS") operated Risk Adjustment Data Validation under the ACA's HHS-operated Risk Adjustment Program published December 1, 2020 and any estimated amounts receivable from or due to CMS are included in premiums and considerations and aggregate health policy reserves, respectively, in the statutory basis statements of assets, liabilities, and capital and surplus. Premium adjustments pursuant to the risk adjustment program are accounted for as premium subject to redetermination and user fees are accounted for as assessments.

Reinsurance — The transitional reinsurance program was designed to protect issuers in the individual market from an expected increase in large claims due to the elimination of preexisting condition limitations. The transitional reinsurance program expired at the end of 2016.

Risk Corridors — The temporary risk corridors program, designed to provide some aggregate protection against variability for issuers in the individual and small group markets during the period 2014 through 2016, applied to Qualified Health Plans in the individual and small group markets both inside and outside of the insurance exchanges. The Company received $272,954 from CMS for the settlement of the temporary ACA risk corridor program which has been reflected in net premium income in the statutory basis statements of operations. The details of the years impacted and the amounts received are included in Note 24E 4 and Note 24E 5 below.

(2) The following table presents the current year impact of risk-sharing provisions of the ACA on assets, liabilities and operations:

		December 31, 2020
a.	**Permanent ACA Risk Adjustment Program**	
	Assets	
1.	Premium adjustments receivable due to ACA Risk Adjustment (including high-risk pool payments)	-
	Liabilities	
2.	Risk adjustment user fees payable for ACA Risk Adjustment	-
3.	Premium adjustments payable due to ACA Risk Adjustment (including high-risk pool premium)	-
	Operations (Revenue & Expense)	
4.	Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment	-
5.	Reported in expenses as ACA Risk Adjustment user fees (incurred/paid)	-
b.	**Transitional ACA Reinsurance Program**	
	Assets	
1.	Amounts recoverable for claims paid due to ACA Reinsurance	$ -
2.	Amounts recoverable for claims unpaid due to ACA Reinsurance (Contra Liability)	-
3.	Amounts receivable relating to uninsured plans for contributions for ACA Reinsurance	-
	Liabilities	
4.	Liabilities for contributions payable due to ACA Reinsurance - not reported as ceded premium	-
5.	Ceded reinsurance premiums payable due to ACA Reinsurance	-
6.	Liabilities for amounts held under uninsured plans contributions for ACA Reinsurance	-
	Operations (Revenue & Expense)	
7.	Ceded reinsurance premiums due to ACA Reinsurance	-
8.	Reinsurance recoveries (income statement) due to ACA reinsurance payments or expected payments	-
9.	ACA Reinsurance contributions - not reported as ceded premium	-
c.	**Temporary ACA Risk Corridors Program**	
	Assets	
1.	Accrued retrospective premium due to ACA Risk Corridors	$ -
	Liabilities	
2.	Reserve for rate credits or policy experience rating refunds due to ACA Risk Corridors	-
	Operations (Revenue & Expense)	
3.	Effect of ACA Risk Corridors on net premium income (paid/received)	272,954
4.	Effect of ACA Risk Corridors on change in reserves for rate credits	-

(3) The following table is a rollforward of the prior year ACA risk-sharing provisions for asset and liability balances, along with reasons for adjustments to prior year balances:

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Cumulative Balance From Prior Years	
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Prior Year Accrued Less Payments (Col 1 - 3) Receivable	Prior Year Accrued Less Payments (Col 2 - 4) (Payable)	To Prior Year Balances Receivable	To Prior Year Balances (Payable)	Ref	(Col 1 - 3 + 7) Receivable	(Col 2 - 4 + 8) (Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustment receivable (including high-risk pool payments)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	A	$ -	$ -
2. Premium adjustment (payable) (including high-risk pool premium)	-	-	-	-	-	-	-	-	B	-	-
3. Subtotal ACA Permanent Risk Adjustment Program	-	-	-	-	-	-	-	-		-	-
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	-	-	-	-	-	-	-	-	C	-	-
2. Amounts recoverable for claims unpaid (contra liability)	-	-	-	-	-	-	-	-	D	-	-
3. Amounts receivable relating to uninsured plans	-	-	-	-	-	-	-	-	E	-	-
4. Liabilities for contributions payable due to ACA Reinsurance—not reported as ceded premium	-	-	-	-	-	-	-	-	F	-	-
5. Ceded reinsurance premiums payable	-	-	-	-	-	-	-	-	G	-	-
6. Liability for amounts held under uninsured plans	-	-	-	-	-	-	-	-	H	-	-
7. Subtotal ACA Transitional Reinsurance Program	-	-	-	-	-	-	-	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-	-	272,954	-	(272,954)	-	272,954	-	I	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	J	-	-
3. Subtotal ACA Risk Corridors Program	-	-	272,954	-	(272,954)	-	272,954	-		-	-
d. Total for ACA Risk-Sharing Provisions	$ -	$ -	$ 272,954	$ -	$ (272,954)	$ -	$ 272,954	$ -		$ -	$ -

Explanation of Adjustments

A. N/A
B. N/A
C. N/A
D. N/A
E. N/A
F. N/A
G. N/A
H. N/A
I. As a result of the United States Supreme Court decision on April 27, 2020 in Maine Community Health Options vs. United States, the Federal Government paid the full amount due to the Company under the temporary risk corridors program for the 2014, 2015, and 2016 benefit years. The risk corridor payment was recognized in the statutory basis statements of operations upon receipt in full during the quarter ended December 31, 2020.
J. N/A

(4) The following table discloses risk corridor receivables and payables by risk corridor program year:

Risk Corridors Program Year	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year 1 Receivable	2 (Payable)	Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year 3 Receivable	4 (Payable)	Differences Prior Year Accrued Less Payments (Col 1 - 3) 5 Receivable	Prior Year Accrued Less Payments (Col 2 - 4) 6 (Payable)	Adjustments To Prior Year Balances 7 Receivable	To Prior Year Balances 8 (Payable)	Ref	Unsettled Balances as of the Reporting Date Cumulative Balance From Prior Years (Col 1 - 3 + 7) 9 Receivable	Cumulative Balance From Prior Years (Col 2 - 4 + 8) 10 (Payable)
a. 2014											
1. Accrued retrospective premium	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	A	$ -	$ -
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	B	-	-
b. 2015											
1. Accrued retrospective premium	-	-	115,915	-	(115,915)	-	115,915	-	C	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	D	-	-
c. 2016											
1. Accrued retrospective premium	-	-	157,039	-	(157,039)	-	157,039	-	E	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	F	-	-
d. Total for Risk Corridors	$ -	$ -	$ 272,954	$ -	$ (272,954)	$ -	$ 272,954	$ -		$ -	$ -

Explanation of Adjustments

A. N/A
B. N/A
C. As a result of the United States Supreme Court decision on April 27, 2020 in Maine Community Health Options vs. United States, the Federal Government paid the full amount due to the Company under the temporary risk corridor program covering issuers of qualified health plans in the individual and small group markets for the 2015 benefit year. As of December 31, 2020, the risk corridor payment has been received and is included in net premium income in the statutory basis statements of operations.
D. N/A
E. As a result of the United States Supreme Court decision on April 27, 2020 in Maine Community Health Options vs. United States, the Federal Government paid the full amount due to the Company under the temporary risk corridor program covering issuers of qualified health plans in the individual and small group markets for the 2016 benefit year. As of December 31, 2020, the risk corridor payment has been received and is included in net premium income in the statutory basis statements of operations.
F. N/A

(5) The following table discloses ACA risk corridor receivable balances by risk corridor program year:

Risk Corridors Program Year	1 Estimated Amount to be Filed or Final Amount Filed with CMS	2 Non-Accrued Amounts for Impairment or Other Reasons	3 Amounts Received from CMS	4 Asset Balance (Gross of Non-Admissions) (1-2-3)	5 Non-Admitted Amount	6 Net Admitted Asset (4-5)
a. 2014	$ -	$ -	$ -	$ -	$ -	$ -
b. 2015	115,915	-	115,915	-	-	-
c. 2016	157,039	-	157,039	-	-	-
d. Total (a+b+c)	$ 272,954	$ -	$ 272,954	$ -	$ -	$ -

25. CHANGE IN INCURRED CLAIMS AND CLAIMS ADJUSTMENT EXPENSES

A. Changes in estimates related to the prior year incurred claims are included in total hospital and medical expenses in the current year in the statutory basis statements of operations. The following tables disclose paid claims, incurred claims, and the balance in claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, health care receivables (excluding provider loans and advances not yet expensed) and reinsurance recoverables for the years ended December 31, 2020 and 2019:

	2020		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (111,292,955)	$ (111,292,955)
Paid claims—net of health care receivables* and reinsurance recoveries collected	1,267,094,753	(1,523,660)	1,265,571,093
End of year claim reserve	121,272,136	4,917,968	126,190,104
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	1,388,366,889	(107,898,647)	1,280,468,242
Beginning of year health care receivables* and reinsurance recoverables	-	102,697,784	102,697,784
End of year health care receivables* and reinsurance recoverables	(129,702,795)	(3,670,898)	(133,373,693)
Total incurred claims	$ 1,258,664,094	$ (8,871,761)	$ 1,249,792,333

*Health care receivables excludes provider loans and advances not yet expensed of $30,000 and $60,000 for 2020 and 2019, respectively.

	2019		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (80,332,040)	$ (80,332,040)
Paid claims—net of health care receivables* and reinsurance recoveries collected	1,032,685,462	(17,626,478)	1,015,058,984
End of year claim reserve	105,589,215	5,703,740	111,292,955
Incurred claims excluding the change in health care receivables* and reinsurance recoverables as presented below	1,138,274,677	(92,254,778)	1,046,019,899
Beginning of year health care receivables* and reinsurance recoverables	-	101,140,849	101,140,849
End of year health care receivables* and reinsurance recoverables	(100,053,662)	(2,644,122)	(102,697,784)
Total incurred claims	$ 1,038,221,015	$ 6,241,949	$ 1,044,462,964

*Health care receivables excludes provider loans and advances not yet expensed of $60,000 and $150,000 for 2019 and 2018, respectively.

The liability for claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, net of health care receivables (excluding provider loans and advances not yet expensed), and reinsurance recoverables as of December 31, 2019 was $8,595,171. As of December 31, 2020, $(1,523,660) has been paid for incurred claims attributable to insured events of prior years. Reserves remaining for prior years, net of health care receivables (excluding provider loans and advances not yet expensed) and reinsurance recoverables are now $1,247,070, as a result of re-estimation of unpaid claims. Therefore, there has been $8,871,761 favorable prior year development since December 31, 2019 to December 31, 2020. The primary drivers consist of favorable development as a result of a change in the provision for adverse deviations in experience of $7,283,663 and favorable development of $6,876,828 in retroactivity for inpatient, outpatient, physician, and pharmacy claims, offset by unfavorable development of $3,445,759 in capitation, and unfavorable development of $1,146,240 in provider settlements. At December 31, 2019, the Company recorded $6,241,949 of unfavorable development consisting of unfavorable development of $32,930,366 in retroactivity for inpatient, outpatient, physician, and pharmacy claims, unfavorable development in audit recovery operations recoveries of $5,120,823, offset by favorable development in reinsurance of $15,213,201, favorable development in capitation of $5,862,205, favorable development as a result of a change in the provision for adverse deviations in experience of $4,856,781, favorable development in provider settlements of $3,288,543, and favorable development in risk share of $2,145,209. Original estimates are increased or decreased, as additional information becomes known regarding individual claims, which could have an impact to the accruals for medical loss ratio rebates and retrospectively rated contracts. As a result of the prior year effects, on a regular basis, the Company adjusts revenue and the corresponding liability and/or receivable related to retrospectively rated policies and the impact of the change is included as a component of change in reserve for rate credits in the statutory basis statements of operations.

The Company incurred CAE of $70,100,168 and $52,258,619 in 2020 and 2019, respectively. These costs are included in the management service fees paid by the Company to UHS as a part of the Agreement (see Note 10). The following table discloses paid CAE, incurred CAE, and the balance in unpaid CAE reserve for 2020 and 2019:

	2020	2019
Total claims adjustment expenses	$ 70,100,168	$ 52,258,619
Less: current year unpaid claims adjustment expenses	(2,329,097)	(2,048,408)
Add: prior year unpaid claims adjustment expenses	2,048,408	1,479,607
Total claims adjustment expenses paid	$ 69,819,479	$ 51,689,818

B. The Company did not make any significant changes in methodologies and assumptions used in the calculation of the liability for claims unpaid and unpaid CAE in 2020.

26. INTERCOMPANY POOLING ARRANGEMENTS

A–G. The Company did not have any intercompany pooling arrangements in 2020 or 2019.

27. STRUCTURED SETTLEMENTS

A–B. The Company did not have structured settlements in 2020 or 2019.

28. HEALTH CARE RECEIVABLES

A. Pharmacy rebates receivable are recorded when reasonably estimated or billed by the affiliated pharmaceutical benefit manager in accordance with pharmaceutical rebate contract provisions. Information used to support rebates billed to the manufacturer is based on utilization information gathered by the pharmaceutical benefit manager and adjusted for significant changes in pharmaceutical contract provisions.

The Company evaluates admissibility of all pharmacy rebates receivable based on the administration of each underlying pharmaceutical benefit management agreement. The Company has nonadmitted and excluded all pharmacy rebates receivable that do not meet the admissibility criteria of SSAP No. 84, *Health Care and Government Insured Plan Receivables* ("SSAP No. 84") from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

For each pharmaceutical management agreement for which a portion of the total pharmacy rebates receivable can be admitted based on the admissibility criteria of SSAP No. 84, the pharmacy rebate transaction history is summarized as follows:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received within 90 Days of Billing	Actual Rebates Received within 91 to 180 Days of Billing	Actual Rebates Received More than 180 Days after Billing
12/31/2020	$ 27,553,139	$ 8,714,411	$ -	$ -	$ -
9/30/2020	25,441,589	25,530,422	15,673,262	-	-
6/30/2020	24,816,024	24,702,267	20,419,835	3,361,768	-
3/31/2020	22,708,365	22,442,028	8,879,536	12,990,064	(196,659)
12/31/2019	18,192,106	18,899,841	14,615,042	2,943,819	976,010
9/30/2019	18,462,735	18,762,249	14,403,484	3,166,016	777,746
6/30/2019	18,227,557	18,611,761	13,556,511	4,443,243	288,588
3/31/2019	15,683,107	16,246,365	12,984,210	2,133,898	785,525
12/31/2018	10,754,615	10,666,211	9,212,306	1,404,544	59,008
9/30/2018	9,183,892	9,159,868	7,578,201	1,322,707	241,839
6/30/2018	7,228,707	7,381,753	6,289,235	887,812	195,324
3/31/2018	4,720,041	4,758,306	3,997,593	648,734	117,608

Of the amount reported as health care receivables, $36,966,331 and $25,345,532 relates to pharmacy rebates receivable as of December 31, 2020 and 2019, respectively. This increase is primarily due to increased membership along with the change in generic/name brand mix.

B. The Company has nonadmitted all risk-sharing receivables from the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company also admitted $144,749 and $186,722 of provider overpayment receivables resulting from claim overpayments as of December 31, 2020 and December 31, 2019, respectively, which are included in health care receivables in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

29. PARTICIPATING POLICIES

The Company did not have any participating contracts in 2020 or 2019.

30. PREMIUM DEFICIENCY RESERVES

The following table summarizes the Company's PDR as of December 31, 2020 and 2019:

	2020
1. Liability carried for premium deficiency reserves	$ -
2. Date of the most recent evaluation of this liability	12/31/2020
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

	2019
1. Liability carried for premium deficiency reserves	$ 1,151,000
2. Date of the most recent evaluation of this liability	12/31/2019
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

PDR is included in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

31. ANTICIPATED SALVAGE AND SUBROGATION

Due to the type of business being written, the Company has no salvage. As of December 31, 2020 and 2019, the Company had no specific accruals established for outstanding subrogation, as it is considered a component of the actuarial calculations used to develop the estimates of claims unpaid and aggregate health claim reserves.

* * * * * *

SUPPLEMENTAL SCHEDULES

EXHIBIT I:
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2020
(To Be Filed by April 1)

Of The UnitedHealthcare of the Midwest, Inc.

ADDRESS (City, State and Zip Code) Minnetonka , MN 55343

NAIC Group Code 0707 NAIC Company Code 96385 Federal Employer's Identification Number (FEIN) 43-1361841

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 568,504,706

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	HSBC - HGIXX	Cash Equivalents	$ 11,387,776	2.0 %
2.02	FNMA	Bonds	$ 6,160,602	1.1 %
2.03	FHLMC	Bonds	$ 2,407,254	0.4 %
2.04	Northern Inst - BGSXX	Cash Equivalents	$ 2,149,607	0.4 %
2.05	REGL TRANSPRTN A - TRAN	Bonds	$ 880,509	0.2 %
2.06	Dreyfus - DSHXX	Cash Equivalents	$ 879,574	0.2 %
2.07	Dreyfus - DGCXX	Cash Equivalents	$ 857,163	0.2 %
2.08	W CONTRA COSTA C - GEN	Bonds	$ 774,043	0.1 %
2.09	S FL WTR MGMT DI - CTF	Bonds	$ 767,622	0.1 %
2.10	REEDY CREEK FL I - GEN	Bonds	$ 728,417	0.1 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 44,064,720	7.8 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 7,997,199	1.4 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 0	0.0 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 0	0.0 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 0	0.0 %	3.11	P/RP-5	$ 0	0.0 %
3.06	NAIC-6	$ 0	0.0 %	3.12	P/RP-6	$ 0	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 46,137	0.0 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 0	0.0 %
5.02	Countries designated NAIC-2	$ 0	0.0 %
5.03	Countries designated NAIC-3 or below	$ 0	0.0 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1:	$ 0	0.0 %
6.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
6.03	Country 1:	$ 0	0.0 %
6.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1:	$ 0	0.0 %
6.06	Country 2:	$ 0	0.0 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$ 0	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$ 0	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1:	$ 0	0.0 %
9.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$ 0	0.0 %
9.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$ 0	0.0 %
9.06	Country 2:	$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01			$ 0	0.0 %
10.02			$ 0	0.0 %
10.03			$ 0	0.0 %
10.04			$ 0	0.0 %
10.05			$ 0	0.0 %
10.06			$ 0	0.0 %
10.07			$ 0	0.0 %
10.08			$ 0	0.0 %
10.09			$ 0	0.0 %
10.10			$ 0	0.0 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 0	0.0 %
11.03	Canadian-currency-denominated investments	$ 0	0.0 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.0 %
11.05	Unhedged Canadian currency exposure	$ 0	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$ 0	0.0 %
12.04		$ 0	0.0 %
12.05		$ 0	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for 14.02 through 14.05.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.0 %
14.04		$ 0	0.0 %
14.05		$ 0	0.0 %

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06		$ 0	$ 0	$ 0
14.07		$ 0	$ 0	$ 0
14.08		$ 0	$ 0	$ 0
14.09		$ 0	$ 0	$ 0
14.10		$ 0	$ 0	$ 0
14.11		$ 0	$ 0	$ 0
14.12		$ 0	$ 0	$ 0
14.13		$ 0	$ 0	$ 0
14.14		$ 0	$ 0	$ 0
14.15		$ 0	$ 0	$ 0

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.0 %
	Largest three investments in general partnership interests:		
15.03		$ 0	0.0 %
15.04		$ 0	0.0 %
15.05		$ 0	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ 0	0.0 %
16.03		$ 0	0.0 %
16.04		$ 0	0.0 %
16.05		$ 0	0.0 %
16.06		$ 0	0.0 %
16.07		$ 0	0.0 %
16.08		$ 0	0.0 %
16.09		$ 0	0.0 %
16.10		$ 0	0.0 %
16.11		$ 0	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.0 %
16.15	Mortgage loans foreclosed	$ 0	0.0 %
16.16	Restructured mortgage loans	$ 0	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential			Commercial			Agricultural	
	Loan to Value	1	2		3	4		5	6
17.01	above 95%	$ 0	0.0 %		$ 0	0.0 %		$ 0	0.0 %
17.02	91 to 95%	$ 0	0.0 %		$ 0	0.0 %		$ 0	0.0 %
17.03	81 to 90%	$ 0	0.0 %		$ 0	0.0 %		$ 0	0.0 %
17.04	71 to 80%	$ 0	0.0 %		$ 0	0.0 %		$ 0	0.0 %
17.05	below 70%	$ 0	0.0 %		$ 0	0.0 %		$ 0	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ 0	0.0 %
18.03		$ 0	0.0 %
18.04		$ 0	0.0 %
18.05		$ 0	0.0 %
18.06		$ 0	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$ 0	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.0 %
19.04		$ 0	0.0 %
19.05		$ 0	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.0 %	$ 0	$ 0	$ 0
20.02	Repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 0	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ 0	0.0 %
21.03	Other	$ 0	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

EXHIBIT II:
SUMMARY INVESTMENT SCHEDULE

SUMMARY INVESTMENT SCHEDULE

	Investment Categories	Gross Investment Holdings 1 Amount	Gross Investment Holdings 2 Percentage of Column 1 Line 13	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage of Column 5 Line 13
1.	Long-Term Bonds (Schedule D, Part 1):						
	1.01 U.S. governments	4,641,308	2.571	4,641,309	0	4,641,309	2.571
	1.02 All other governments	299,639	0.166	299,639	0	299,639	0.166
	1.03 U.S. states, territories and possessions, etc. guaranteed	1,552,302	0.860	1,552,302	0	1,552,302	0.860
	1.04 U.S. political subdivisions of states, territories, and possessions, guaranteed	2,554,809	1.415	2,554,810	0	2,554,810	1.415
	1.05 U.S. special revenue and special assessment obligations, etc. non-guaranteed	18,543,759	10.271	18,543,758	0	18,543,758	10.271
	1.06 Industrial and miscellaneous	24,470,102	13.554	24,470,101	0	24,470,101	13.554
	1.07 Hybrid securities	0	0.000	0	0	0	0.000
	1.08 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	1.09 SVO identified funds	0	0.000	0	0	0	0.000
	1.10 Unaffiliated Bank loans	0	0.000	0	0	0	0.000
	1.11 Total long-term bonds	52,061,919	28.836	52,061,919	0	52,061,919	28.836
2.	Preferred stocks (Schedule D, Part 2, Section 1):						
	2.01 Industrial and miscellaneous (Unaffiliated)	0	0.000	0	0	0	0.000
	2.02 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	2.03 Total preferred stocks	0	0.000	0	0	0	0.000
3.	Common stocks (Schedule D, Part 2, Section 2):						
	3.01 Industrial and miscellaneous Publicly traded (Unaffiliated)	0	0.000	0	0	0	0.000
	3.02 Industrial and miscellaneous Other (Unaffiliated)	0	0.000	0	0	0	0.000
	3.03 Parent, subsidiaries and affiliates Publicly traded	0	0.000	0	0	0	0.000
	3.04 Parent, subsidiaries and affiliates Other	0	0.000	0	0	0	0.000
	3.05 Mutual funds	0	0.000	0	0	0	0.000
	3.06 Unit investment trusts	0	0.000	0	0	0	0.000
	3.07 Closed-end funds	0	0.000	0	0	0	0.000
	3.08 Total common stocks	0	0.000	0	0	0	0.000
4.	Mortgage loans (Schedule B):						
	4.01 Farm mortgages	0	0.000	0	0	0	0.000
	4.02 Residential mortgages	0	0.000	0	0	0	0.000
	4.03 Commercial mortgages	0	0.000	0	0	0	0.000
	4.04 Mezzanine real estate loans	0	0.000	0	0	0	0.000
	4.05 Total valuation allowance	0	0.000	0	0	0	0.000
	4.06 Total mortgage loans	0	0.000	0	0	0	0.000
5.	Real estate (Schedule A):						
	5.01 Properties occupied by company	0	0.000	0	0	0	0.000
	5.02 Properties held for production of income	0	0.000	0	0	0	0.000
	5.03 Properties held for sale	0	0.000	0	0	0	0.000
	5.04 Total real estate	0	0.000	0	0	0	0.000
6.	Cash, cash equivalents and short-term investments:						
	6.01 Cash (Schedule E, Part 1)	38,778	0.021	38,778	0	38,778	0.021
	6.02 Cash equivalents (Schedule E, Part 2)	128,441,832	71.142	128,441,832	0	128,441,832	71.142
	6.03 Short-term investments (Schedule DA)	0	0.000	0	0	0	0.000
	6.04 Total cash, cash equivalents and short-term investments	128,480,610	71.164	128,480,610	0	128,480,610	71.164
7.	Contract loans	0	0.000	0	0	0	0.000
8.	Derivatives (Schedule DB)	0	0.000	0	0	0	0.000
9.	Other invested assets (Schedule BA)	0	0.000	0	0	0	0.000
10.	Receivables for securities	0	0.000	0	0	0	0.000
11.	Securities Lending (Schedule DL, Part 1)	0	0.000	0	XXX	XXX	XXX
12.	Other invested assets (Page 2, Line 11)	0	0.000	0	0	0	0.000
13.	Total invested assets	180,542,529	100.000	180,542,529	0	180,542,529	100.000

EXHIBIT III:
SUPPLEMENTAL SCHEDULE
REGARDING REINSURANCE CONTRACTS
WITH RISK-LIMITING FEATURES

UNITEDHEALTHCARE OF THE MIDWEST, INC.

FOR THE YEAR ENDED DECEMBER 31, 2020
SUPPLEMENTAL SCHEDULE OF THE ANNUAL AUDIT REPORT
SUPPLEMENTAL SCHEDULE REGARDING REINSURANCE CONTRACTS WITH RISK-LIMITING FEATURES

Reinsurance contracts subject to *Appendix A-791—Life and Health Reinsurance Agreements* of the *NAIC Accounting Practices and Procedures Manual:*

The Company has no reinsurance contracts subject to Appendix A-791 – *Life and Health Reinsurance Agreements* ("A-791") that includes a provision which limits the reinsurer's assumption of significant risk.

Reinsurance contracts NOT subject to *Appendix A-791—Life and Health Reinsurance Agreements* of the *NAIC Accounting Practices and Procedures Manual:*

The Company has no reinsurance contracts not subject to A-791, for which reinsurance accounting was applied and which include a provision that limits the reinsurer's assumption of risk.

Payments to reinsurers (excluding reinsurance contracts with a federal or state facility):

The Company's reinsurance contracts do not contain features which result in delays in payment in form or in fact.

Reinsurance contracts NOT subject to *Appendix A-791—Life and Health Reinsurance Agreements* of the *NAIC Accounting Practices and Procedures Manual* and NOT yearly-renewable term that meet the risk transfer requirements under SSAP No. 61R*:*

The Company has not reflected a reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk transfer requirements of SSAP No. 61R, Life, Deposit-Type, and Accident and Health Reinsurance ("SSAP No. 61R").

The Company did not cede any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract during the period covered by these financial statements, for which the statutory accounting treatment and GAAP accounting treatment were not the same.

The Company's ceded reinsurance contract which is not subject to A-791 and not yearly renewable term reinsurance, is treated the same for GAAP and statutory accounting principles.

OTHER ATTACHMENT

Deloitte.

Deloitte & Touche LLP
Certified Public Accountants
333 Southeast 2nd Avenue
Suite 3600
Miami, FL 33131
USA

Tel:+1 305 372 3100
Fax:+1 305 372 3160
www.deloitte.com

To the Audit Committee of
UnitedHealthcare of the Midwest, Inc.
13655 Riverport Drive, MO050-1000
Maryland Heights, MO 63043

The Management of
UnitedHealthcare of the Midwest, Inc.
13655 Riverport Drive, MO050-1000
Maryland Heights, MO 63043

Dear Members of the Audit Committee and Management:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the statutory basis financial statements of UnitedHealthcare of the Midwest, Inc. (the "Company") for the years ended December 31, 2020, and 2019, and have issued our report thereon dated April 23, 2021. In connection therewith, we advise you as follows:

1. We are independent certified public accountants with respect to the Company and conform to the standards of the accounting profession as contained in the *Code of Professional Conduct* and pronouncements of the American Institute of Certified Public Accountants, the rules and regulations of the Missouri Department of Insurance, and the Rules of Professional Conduct of the Florida Board of Accountancy.

2. The engagement partner and engagement manager, who are certified public accountants, have 21 years and 8 years, respectively, of experience in public accounting and are experienced in auditing insurance enterprises. Members of the engagement team, most of whom have had experience in auditing insurance enterprises and 32 percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

3. We understand that the Company intends to file its audited statutory basis financial statements and our report thereon with the Missouri Department of Insurance and other state insurance departments in states in which the Company is licensed and that the insurance commissioners of those states will be relying on that information in monitoring and regulating the statutory basis financial condition of the Company.

While we understand that an objective of issuing a report on the statutory basis financial statements is to satisfy regulatory requirements, our audit was not planned to satisfy all objectives or responsibilities of insurance regulators. In this context, the Company and insurance commissioners should understand that the objective of an audit of statutory basis financial statements in accordance with auditing standards generally accepted in the United States of America is to form an opinion and issue a report on whether the statutory basis financial statements present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus, results of operations and cash flows in accordance with accounting practices prescribed or permitted by the Missouri Department of Insurance. Consequently, under auditing standards generally accepted in the United States of America, we have the responsibility, within the inherent limitations of the auditing process, to plan and perform our audit to obtain reasonable assurance regarding whether the statutory basis financial statements are free from material misstatement, whether due to error or fraud, and to exercise due professional care in the conduct of the audit. The Company is not required to have, nor were we engaged to perform, an audit of internal

control over financial reporting. Our audit included consideration of internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control over financial reporting. The concept of selective testing of the data being audited, which involves judgment both as to the number of transactions to be audited and the areas to be tested, has been generally accepted as a valid and sufficient basis for an auditor to express an opinion on financial statements. Audit procedures that are effective for detecting errors, if they exist, may be ineffective for detecting misstatements resulting from fraud. Because of the characteristics of fraud, particularly those involving concealment and falsified documentation (including forgery), a properly planned and performed audit may not detect a material misstatement resulting from fraud. In addition, an audit does not address the possibility that material misstatements may occur in the future. Also, our use of professional judgment and the assessment of materiality for the purpose of our audit mean that matters may exist that would have been assessed differently by insurance commissioners.

It is the responsibility of the management of the Company to adopt sound accounting policies, to maintain an adequate and effective system of accounts, and to establish and maintain internal control that will, among other things, provide reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition and that transactions are executed in accordance with management's authorization and are recorded properly to permit the preparation of financial statements in conformity with accounting practices prescribed or permitted by the Missouri Department of Insurance.

The Insurance Commissioner should exercise due diligence to obtain whatever other information that may be necessary for the purpose of monitoring and regulating the statutory basis financial position of insurers and should not rely solely on the independent auditors' report.

4. We will retain the working papers (including those kept in a hard copy or electronic medium) prepared in the conduct of our audit until the Missouri Department of Insurance has filed a Report of Examination covering 2020, but no longer than seven years. After notification to the Company, we will make the working papers available for review by the Missouri Department of Insurance or its delegates, at the offices of the insurer, at our offices, at the Missouri Department of Insurance, or at any other reasonable place designated by the Insurance Commissioner. Furthermore, in the conduct of the aforementioned periodic review by the Missouri Department of Insurance, photocopies of pertinent audit working papers may be made (under the control of Deloitte & Touche LLP) and such copies may be retained by the Missouri Department of Insurance. In addition, to the extent requested, we may provide the Missouri Department of Insurance with copies of certain audit working papers (such as unlocked copies of Excel spreadsheets that do not contain password protection or encryption). As such, these audit working papers will be subject to potential modification by Missouri Department of Insurance or by others. We are not responsible for any modifications made to the copies, electronic or otherwise, after they are provided to the Missouri Department of Insurance; and we are likewise not responsible for any effect that any such modifications, whether intentional or not, might have on the process, substance, or outcome of your regulatory examination.

5. The engagement partner has served in this capacity with respect to the Company since 2019, is licensed by the Florida Board of Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

6. To the best of our knowledge and belief, we are in compliance with the requirements of section 7 of the *NAIC's Model Rule (Regulation) Requiring Annual Audited Financial Reports* regarding qualifications of independent certified public accountants.

This letter is intended solely for the information and use of the Audit Committee and management of UnitedHealthcare of the Midwest, Inc. and for filing with the Missouri Department of Insurance and other state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Deloitte & Touche LLP

April 23, 2021

UnitedHealth Group Form 10-K – 2022

Parent Company Audited Financial Statements

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE FISCAL YEAR ENDED December 31, 2022

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE TRANSITION PERIOD FROM _____ TO _____

Commission file number: 1-10864

UNITEDHEALTH GROUP

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Delaware **(State or other jurisdiction of incorporation or organization)**	**41-1321939** **(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota** **(Address of principal executive offices)**	**55343** **(Zip Code)**

(952) 936-1300
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $.01 par value	**UNH**	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐
Smaller reporting company ☐ Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements. ☐

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b). ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2022 was $479,550,880,245 (based on the last reported sale price of $513.63 per share on June 30, 2022 as reported on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 31, 2023, there were 932,846,602 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2023 Annual Meeting of Shareholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

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PART I

ITEM 1. BUSINESS

OUR BUSINESSES

Overview

The terms "we," "our," "us," "its," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

UnitedHealth Group Incorporated is a health care and well-being company with a mission to help people live healthier lives and help make the health system work better for everyone. Our two distinct, yet complementary business platforms—Optum and UnitedHealthcare—are working to help build a modern, high-performing health system through improved access, affordability, outcomes and experiences for the individuals and organizations we are privileged to serve.

The ability to analyze complex data and apply deep health care expertise and insights allows us to serve people, care providers, businesses, communities and governments with more innovative products and complete, end-to-end offerings for many of the biggest challenges facing health care today.

Optum combines clinical expertise, technology and data to empower people, partners and providers with the guidance and tools they need to achieve better health. Optum serves the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its Optum Health, Optum Insight and Optum Rx businesses. These businesses improve overall health system performance by optimizing care quality and delivery, reducing costs and improving consumer and provider experience, leveraging distinctive capabilities in data and analytics, pharmacy care services, health care operations, population health and health care delivery.

UnitedHealthcare offers a full range of health benefits, enabling affordable coverage, simplifying the health care experience and delivering access to high-quality care. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and individual consumers. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants.

We have four reportable segments:

- Optum Health;
- Optum Insight;
- Optum Rx; and
- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State.

Optum

Optum is an information and technology-enabled health services business serving the broad health care marketplace, including:

- Those who need care: consumers who need the right care, information, resources, products and engagement to improve their health, achieve their health goals and receive an improved patient experience that is personalized and holistic and delivered in all care settings, including in-home and virtually.
- Those who provide care: pharmacies, hospitals, physicians and other health care facilities seeking to improve the health system and reduce the administrative burden allowing for providers to focus time on patients leading to the best possible patient care and experiences while achieving better health outcomes at lower costs. Improved health outcomes are achieved

by leveraging our clinical expertise, data and analytics to better predict, prevent and intercept consumers' health conditions and ensure they receive the best evidence-based care.

- Those who pay for care: employers; health plans; and state, federal and municipal agencies devoted to ensuring the people they sponsor receive high-quality care, administered and delivered efficiently and effectively, all while driving health equity so that every individual, family and community has access to the care they need.
- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines to improve care delivery and health outcomes.

Optum operates three business segments leveraging distinctive capabilities in health care delivery, population health, health care operations, data and analytics and pharmacy care services:

- Optum Health delivers care, care management, wellness and consumer engagement, and health financial services;
- Optum Insight offers data, analytics, research, consulting, technology and managed services solutions; and
- Optum Rx provides diversified pharmacy care services.

Optum Health

Optum Health provides comprehensive and patient-centered care, addressing the physical, mental, social, and financial well-being of 102 million consumers and serves more than 100 health payer partners. We engage people in the most appropriate care settings, including clinical sites, in-home and virtual. Optum Health delivers primary, multi-specialty, behavioral, surgical and urgent care; helps patients and providers navigate and address complex, chronic and behavioral health needs; offers post-acute care planning services; and serves consumers and care providers through advanced, on-demand digital health technologies, such as telehealth and remote patient monitoring, and innovative health care financial services. Optum Health works directly with consumers, care delivery systems, providers, employers, payers, and public-sector entities to provide high quality, accessible and equitable care with improved health outcomes and reduced total cost of care.

Optum Health enables care providers to transition from traditional fee-for-service payment models to performance-based delivery and payment models designed to improve patient health outcomes and experience through value-based care. Through strategic partnerships, alliances and ownership arrangements, Optum Health helps care providers adopt new approaches and technologies improving the coordination of care across providers to serve patients more comprehensively.

Optum Health offerings include fully accountable value-based arrangements, where Optum Health assumes responsibility for health care costs in exchange for a monthly premium. Offerings also include administrative fee arrangements, where Optum Health manages or administers products and services in exchange for a monthly fee, and fee-for-service arrangements, where Optum Health delivers health-related products and medical services for patients at a contracted fee.

Optum Financial, including Optum Bank, serves consumers through nearly 20 million consumer accounts with nearly $20 billion in assets under management as of December 31, 2022. Organizations across the health system rely on Optum Financial to manage and improve payment flows through its highly automated, scalable, end-to-end digital payment systems and integrated card solutions. For financial services offerings, Optum Financial charges fees and earns investment income on managed funds.

Optum Health sells its products primarily through its direct sales force, strategic collaborations and external producers in three key areas: employers, including large, mid-sized and small employers; payers including health plans, third-party administrators (TPAs), underwriter/stop-loss carriers and individual product intermediaries; and public entities including the U.S. Departments of Health and Human Services (HHS), Veterans Affairs, Defense, and other federal, state and local health care agencies.

Optum Insight

Optum Insight connects the health care system with services, analytics and platforms that make clinical, administrative and financial processes simpler and more efficient for all participants in the health care system. Hospital systems, physicians, health plans, public entities, life sciences companies and other organizations comprising the health care industry depend on Optum Insight to help them improve performance and reduce costs through administrative efficiency and payment simplification, advance care quality through evidence-based standards built directly into clinical workflows, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.

Health Systems. Serves hospitals, physicians and other care providers to improve operating performance, better coordinate care and reduce administrative costs through technology and services to improve population health management, patient engagement, revenue cycle management and strategic growth plans.

Health Plans. Serves health plans by improving financial performance and enhancing outcomes through proactive analytics, a comprehensive payment integrity portfolio and technology-enabled and staff-supported risk and quality services. Optum Insight helps health plans navigate a dynamic environment defined by shifts in employer vs. public-sector coverage, the demand for affordable benefit plans and the need to leverage new technology to reduce complexity.

State Governments. Provides advanced technology and analytics services to modernize the administration of critical safety net programs, such as Medicaid, while improving cost predictability.

Life Sciences Companies. Combines data and analytics expertise with comprehensive technologies and health care knowledge to help life sciences companies, including those in pharmaceuticals and medical technology, adopt a more comprehensive approach to advancing therapeutic discoveries and improving clinical outcomes.

Many of Optum Insight's software and information products and professional services are delivered over extended periods, often several years. Optum Insight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with Optum Insight's customers. Optum Insight's aggregate backlog as of December 31, 2022 was approximately $30.0 billion, of which $16.8 billion is expected to be realized within the next 12 months. The aggregate backlog includes $10.7 billion related to affiliated agreements. Optum Insight's aggregate backlog as of December 31, 2021, was $22.4 billion, including $8.9 billion related to affiliated agreements.

Optum Insight's products and services are sold primarily through a direct sales force. Optum Insight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface Optum Insight's products with their applications.

Optum Rx

Optum Rx provides a full spectrum of pharmacy care services through its network of more than 67,000 retail pharmacies, through home delivery, specialty and community health pharmacies, the provision of in-home and community-based infusion services and through rare disease and gene therapy support services. It also offers direct-to-consumer solutions.

Optum Rx manages a broad range of prescription drug spend, including widely available retail drugs as well as limited and ultra-limited distribution drugs in oncology, HIV, pain management and ophthalmology. Optum Rx serves the growing pharmacy needs of people with behavioral health and substance use disorders. In 2022, Optum Rx managed $124 billion in pharmaceutical spending, including $52 billion in specialty pharmaceutical spending.

Optum Rx serves health benefits providers, large national employer plans, unions and trusts, purchasing coalitions and public-sector entities. Optum Rx sells its services through direct sales, health insurance brokers and other health care consultants.

Optum Rx offers multiple clinical programs, digital tools and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner which are designed to deliver improved consumer experiences, better health outcomes and a lower total cost of care. Optum Rx provides various utilization management, medication management, quality assurance, adherence and counseling programs to complement each client's plan design and clinical strategies. Optum Rx is accelerating the integration of medical, pharmacy and behavioral care and treating the whole patient by embedding our pharmacists as key members of the patient care team.

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, creating a better health care experience for its customers and helping to control rising health care costs. UnitedHealthcare's market position is built on:

- strong local-market relationships;
- the breadth of product offerings, based upon extensive expertise in distinct market segments in health care;
- service and advanced technology, including digital consumer engagement;
- competitive medical and operating cost positions;
- effective clinical engagement; and
- innovation for customers and consumers.

UnitedHealthcare uses Optum's capabilities to help coordinate and provide patient care, improve affordability of medical care, analyze cost trends, manage pharmacy care services, work with care providers more effectively and create a simpler and more satisfying consumer and physician experience.

In the United States, UnitedHealthcare arranges for discounted access to care through networks which, as of December 31, 2022, include 1.7 million physicians and other health care professionals and 6,400 hospitals and other facilities.

UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under "Government Regulation" and in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

Domestically, UnitedHealthcare Employer & Individual offers a comprehensive array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses, and individuals. As of December 31, 2022, UnitedHealthcare Employer & Individual provides access to medical services for 26.7 million people. Globally, UnitedHealthcare Employer & Individual serves nearly 7.7 million people with medical and dental benefits, typically in exchange for a monthly premium per member, residing principally in Brazil, Chile, Colombia and Peru, but also in more than 150 other countries. UnitedHealthcare Employer & Individual offers health care delivery in our principal global markets through nearly 45 hospitals, and more than 200 outpatient and ambulatory clinics and surgery centers to UnitedHealthcare Employer & Individual global members and consumers served by other payers.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium which is typically a fixed rate per individual served for a one-year period. Through its administrative and other management services arrangements to customers who elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision professionals. UnitedHealthcare Employer & Individual is focused on providing informed benefit solutions that create

customized plan designs and clinical programs for employers that contribute to well-being and reduce the total cost of care along with providing simpler consumer experiences in response to market dynamics.

UnitedHealthcare Employer & Individual typically distributes its products through a variety of channels, dependent upon the specific product, including: through consultants or direct sales, in collaboration with brokers and agents, through wholesale agents or agencies who contract with health insurance carriers to distribute individual or group benefits, through professional employer organizations and associations and through both multi-carrier and its own proprietary private exchange marketplaces.

UnitedHealthcare Employer & Individual's major product families include consumer engagement products, such as high-deductible consumer driven benefit plans and a variety of innovative consumer centric products; traditional products; clinical and pharmacy products; and specialty benefits, such as vision, dental, hearing, accident protection, critical illness, disability and hospital indemnity offerings.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs. UnitedHealthcare Medicare & Retirement has distinct benefit designs, pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products allowing people choice in obtaining the health coverage and services they need as their circumstances change. These offerings include care management and health system navigator services, clinical management programs, nurse health line services, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients, including AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through agents, employer groups and digital channels.

Major product categories include:

Medicare Advantage. Provides health care coverage for seniors and other eligible Medicare beneficiaries through the Medicare Advantage program administered by the Centers for Medicare & Medicaid Services (CMS), including Medicare Advantage HMO plans, Preferred Provider Organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health benefits coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, monthly consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which individuals reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. UnitedHealthcare Medicare & Retirement served 7.1 million people through its Medicare Advantage products as of December 31, 2022.

We have continued to enhance our offerings, focusing on more digital and physical care resources in the home, expanding our concierge navigation services and enabling the home as a safe and effective setting of care. For example, through our HouseCalls program, nurse practitioners performed nearly 2.3 million clinical preventive home care visits in 2022 to address unmet care opportunities and close gaps in care.

Medicare Part D. Provides Medicare Part D benefits to beneficiaries through its Medicare Advantage and stand-alone Medicare Part D plans. The stand-alone Medicare Part D plans address a large spectrum of people's needs and preferences for their prescription drug coverage, including low-cost prescription options. As of December 31, 2022, UnitedHealthcare enrolled 9.6 million people in the Medicare Part D programs, including 3.3 million individuals in stand-alone Medicare Part D plans, with the remainder in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. Provides a full range of supplemental products at diverse price points. These products cover various levels of coinsurance and deductible gaps to which seniors are exposed in the traditional Medicare program. UnitedHealthcare Medicare & Retirement served 4.4 million seniors nationwide through various Medicare Supplement products in association with AARP as of December 31, 2022.

Premium revenues from CMS represented 38% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2022, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs caring for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage, typically in exchange for a monthly premium per member from the state program. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, including Temporary Assistance to Needy Families; Children's Health Insurance Programs (CHIP); Dual SNPs (DSNPs); Long-Term Services and Supports (LTSS); Aged, Blind and Disabled; and other federal, state and community health care programs. As of December 31, 2022, UnitedHealthcare Community & State participated in programs in 35 states and the District of Columbia, and served 8.2 million people; including 1.5 million people through Medicaid expansion programs in 19 states under the Patient Protection and Affordable Care Act (ACA).

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. These health plans and care programs are designed to address the complex needs of the populations they serve, including the chronically ill, people with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in medically underserved areas and are less likely to have a consistent relationship with the medical community or a care provider. They also often face significant social and economic challenges.

GOVERNMENT REGULATION

Our businesses are subject to comprehensive U.S. federal and state and international laws and regulations. We are regulated by agencies which generally have discretion to issue regulations and interpret and enforce laws and rules. U.S. federal and state and international governments continue to consider and enact various legislative and regulatory proposals which could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political environment, could adversely affect our businesses.

See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our compliance with U.S. federal and state and international laws and regulations.

U.S. Federal Laws and Regulation

When we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations, including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amounts of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to medical loss ratios (MLRs) and risk adjustment data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts, which are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance, and the regulatory environment with respect to these programs is complex.

Our businesses are also subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriate reduction or limitation of health care services, anti-money laundering, securities and antitrust compliance.

Privacy, Security and Data Standards Regulation. Certain of our operations are subject to regulation under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), which apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets and for the privacy and security of protected health information.

Our businesses must comply with the Health Information Technology for Economic and Clinical Health Act (HITECH) which regulates matters relating to privacy, security and data standards. HITECH imposes requirements on uses and disclosures of health information; includes contracting requirements for HIPAA business associate agreements; extends parts of HIPAA privacy and security provisions to business associates; adds federal data breach notification requirements for covered entities and business associates and reporting requirements to HHS and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthens enforcement and imposes higher financial penalties for HIPAA violations and, in certain cases, imposes criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate.

The use and disclosure of individually identifiable health data by our businesses are also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and generally prescribe safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations, which may apply to us, as discussed below. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations subject to interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee health benefit plans, particularly those who maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for administration of benefits, claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations, which require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. We are required to maintain a risk management framework and file a confidential self-assessment report with state insurance regulators. We file reports annually with Connecticut, our lead regulator, and with New York, as required by the state's regulation.

Our health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports describing capital structure, ownership, financial condition, certain affiliated transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material affiliated transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, Managed Care Organization (MCO), utilization review (UR), TPA, pharmacy care services, durable medical equipment or care provider-related regulations and licensure requirements. These regulations differ from state to state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. Health care-related laws and regulations set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distribution laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies which oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our beneficiaries dually eligible for Medicare and Medicaid. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

State Privacy and Security Regulations. A number of states have adopted laws and regulations which may affect our privacy and security practices, such as state laws governing the use, disclosure and protection of social security numbers and protected health information or which are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to meet minimum cyber-security standards and notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Different approaches to state privacy and insurance regulation and varying enforcement philosophies may materially and adversely affect our ability to standardize our products and services across state lines. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws prohibiting specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from engaging in fee-splitting practices, which involve sharing in the fees or revenues of a professional practice. These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation. The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Pharmacy and Pharmacy Benefits Management (PBM) Regulations

Optum Rx’s businesses include home delivery, specialty and compounding pharmacies, as well as clinic-based pharmacies which must be licensed as pharmacies in the states in which they are located. Certain of our pharmacies must also register with the U.S. Drug Enforcement Administration (DEA) and individual state controlled substance authorities to dispense controlled substances. In addition to adhering to the laws and regulations in the states where our pharmacies are located, we also are required to comply with laws and regulations in some non-resident states where we deliver pharmaceuticals, including those requiring us to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our pharmacies to follow the laws of the state in which the pharmacies are located, but some non-resident states also require us to comply with their laws where pharmaceuticals are delivered. Additionally, certain of our pharmacies which participate in programs for Medicare and state Medicaid providers are required to comply with applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to our pharmacy care services businesses.

Federal and state legislation regulating PBM activities affects both our ability to limit access to a pharmacy provider network or remove network providers. Additionally, many states limit our ability to manage and establish maximum allowable costs for generic prescription drugs. With respect to formulary services, a number of government entities, including CMS, HHS and state departments of insurance, regulate the administration of prescription drug benefits offered through federal or state exchanges.

Many states also regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. These regulations could limit or preclude (i) certain plan designs, (ii) limited networks, (iii) use of particular care providers or distribution channels, (iv) copayment differentials among providers and (v) formulary tiering practices.

Legislation seeking to regulate PBM activities introduced or enacted at the federal or state level could impact our business practices with others in the pharmacy supply chain, including pharmaceutical manufacturers and network providers. In addition, organizations like the NAIC periodically issue model regulations while credentialing organizations, like the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), may establish standards impacting PBM pharmacy activities. Although these model regulations and standards do not have the force of law, they may influence states to adopt their recommendations and impact the services we deliver to our clients.

Consumer Protection Laws

Certain of our businesses participate in direct-to-consumer activities and are subject to regulations applicable to online communications and other general consumer protection laws and regulations such as the Federal Tort Claims Act, the Federal Postal Service Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws.

Certain laws, such as the Telephone Consumer Protection Act, give the FTC, the Federal Communications Commission (FCC) and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation (FDIC), which performs annual examinations to ensure the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

Non-U.S. Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes vary from jurisdiction to jurisdiction. In addition, our non-U.S. businesses and operations are subject to U.S. laws regulating the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health care company, we operate in highly competitive markets across the full expanse of health care benefits and services. Our competitors include organizations ranging from startups to highly sophisticated Fortune 50 global enterprises, for-profit and non-profit companies, and private and government-sponsored entities. New entrants to our markets and business combinations among our competitors and suppliers also contribute to a dynamic and competitive environment. We compete fundamentally on the quality and value we provide to those we serve which can include elements such as product and service

innovation; use of technology; consumer and provider engagement and satisfaction; and sales, marketing and pricing. See Part I, Item 1A, “Risk Factors” for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, Optum and UnitedHealthcare names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim any proprietary interest in the marks and names of others.

HUMAN CAPITAL RESOURCES

Our nearly 400,000 employees, as of December 31, 2022, including more than 140,000 clinical professionals, are guided by our mission to help people live healthier lives and help make the health system work better for everyone. Our mission and cultural values of integrity, compassion, relationships, innovation and performance align with our long-term business strategy to increase access to care, make care more affordable, enhance the care experience, improve health outcomes and advance health equity. Our mission and values attract individuals who are determined to make a difference—individuals whose talent, innovation, engagement and empowerment are critical in our ability to achieve our mission. Similar to other businesses, in 2022 we experienced moderately higher levels of employment attrition, but due to increased recruiting capacity, upgraded digital capabilities and continued investment in our workforce, we continue to be able to meet the needs of those we serve.

We are committed to developing our people and culture by creating an inclusive environment where people of diverse backgrounds, experiences and perspectives make us better. Our approach is data-driven and leader led and uses enterprise and business scorecards to ensure our leaders are accountable for a consistent focus on hiring, developing, advancing and retaining diverse talent. We have embedded inclusion and diversity throughout our culture, including in our talent acquisition and talent management practices; leadership development; careers; learning and skills; and systems and processes. We strive to maintain a sustainable and diverse talent pipeline by building strong strategic partnerships and outreach through early career programs, internships and apprenticeships. We support career coaching, mentorship and accelerated leadership development programs to ensure mobility and advancement for our diverse talent. To foster an engaged workforce and an inclusive culture, we invest in a broad array of learning and culture development programs. We rely on a shared leadership framework, which clearly and objectively defines our expectations, enables an environment where everyone has the opportunity to learn and grow, and helps us identify, develop and deploy talent to help achieve our mission.

We prioritize pay equity by regularly evaluating and reviewing our compensation practices by gender, ethnicity and race. Receiving on-going feedback from our team members is another way to strengthen and reinforce a culture of inclusion. Our Employee Experience Index measures an employee’s sense of commitment and belonging to our company and is a metric in the Stewardship section of our annual incentive plan. Our Sustainability Report, which can be accessed on our website at www.unitedhealthgroup.com, provides further information about our people and culture.

INFORMATION ABOUT OUR EXECUTIVE OFFICERS

The following sets forth certain information regarding our executive officers as of February 24, 2023, including the business experience of each executive officer during the past five years:

Name	Age	Position
Andrew Witty	58	Chief Executive Officer
Dirk McMahon	63	President and Chief Operating Officer
John Rex	61	Executive Vice President and Chief Financial Officer
Rupert Bondy	61	Executive Vice President, Chief Legal Officer and Corporate Secretary
Erin McSweeney	58	Executive Vice President and Chief People Officer
Thomas Roos	50	Senior Vice President and Chief Accounting Officer
Brian Thompson	48	Chief Executive Officer of UnitedHealthcare

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Andrew Witty has served as Chief Executive Officer and a member of the Board of Directors of UnitedHealth Group since February 2021. Previously, Andrew served as Chief Executive Officer of Optum from July 2018 to April 2021, President of UnitedHealth Group from November 2019 to February 2021 and as a UnitedHealth Group director from August 2017 to March 2018. Prior to joining UnitedHealth Group, he was Chief Executive Officer and a board member of GlaxoSmithKline, a global pharmaceutical company, from 2008 to 2017.

Dirk McMahon has served as President and Chief Operating Officer of UnitedHealth Group since February 2021. He previously served as Chief Executive Officer of UnitedHealthcare June 2019 to April 2021, President and Chief Operating Officer of Optum from April 2017 to June 2019 and Executive Vice President, Operations at UnitedHealth Group from November 2014 to April 2017. Dirk also served as Chief Executive Officer of Optum Rx from November 2011 to November 2014. Prior to 2011, he held various positions in UnitedHealthcare in operations, technology and finance.

John Rex has served as Executive Vice President and Chief Financial Officer of UnitedHealth Group since June 2016. From March 2012 to June 2016, he served as Executive Vice President and Chief Financial Officer of Optum. Prior to joining Optum in 2012, John was a Managing Director at JP Morgan, a global financial services firm.

Rupert Bondy has served as Executive Vice President and Chief Legal Officer of UnitedHealth Group since March 2022 and additionally as Corporate Secretary since April 2022. Prior to joining UnitedHealth Group, Rupert served as Senior Vice President, General Counsel and Corporate Secretary at Reckitt Benckiser Group, a consumer goods group focused on hygiene, health and nutrition products, from January 2017 to February 2022. Prior to joining Reckitt Benckieser Group, he served as Group General Counsel of BP plc, an international energy company, and, among his prior positions, as Senior Vice President and General Counsel of GlaxoSmithKline, a global pharmaceutical company.

Erin McSweeney has served as Executive Vice President and Chief People Officer of UnitedHealth Group since March 2022. From February 2021 to March 2022, Erin served as chief of staff to UnitedHealth Group's Office of the Chief Executive. From January 2017 to February 2021, she served as Executive Vice President and Chief Human Resources Officer at Optum. Prior to joining UnitedHealth Group, Erin was Executive Vice President and Chief Human Resources Officer for EMC Corporation, an international technology company.

Tom Roos has served as Senior Vice President and Chief Accounting Officer of UnitedHealth Group since August 2015. Prior to joining UnitedHealth Group, Tom was a Partner at Deloitte & Touche LLP, an independent registered public accounting firm.

Brian Thompson has served as Chief Executive Officer of UnitedHealthcare since April 2021. Prior to this role, he served as Chief Executive Officer of UnitedHealthcare's government programs including Medicare & Retirement and Community & State

from July 2019 to April 2021; as Chief Executive Officer of Medicare & Retirement from April 2017 to July 2019; and as Chief Financial Officer of UnitedHealthcare's Employer & Individual and Medicare & Retirement businesses from August 2010 to April 2017.

Additional Information

Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at www.unitedhealthgroup.com to learn more about our company. We make periodic and current reports and amendments available, free of charge, on our website, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words "believe," "expect," "intend," "estimate," "anticipate," "forecast," "outlook," "plan," "project," "should" or similar words or phrases are intended to identify such forward-looking statements. These statements are intended to take advantage of the "safe harbor" provisions of the PSLRA. These forward-looking statements involve risks and uncertainties which may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement in this report speaks only as of the date of this report and, except as required by law, we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business, which investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other SEC filings or public statements we make may turn out to be wrong. Our forward-looking statements can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. Many factors discussed below will be important in determining our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions which are difficult to predict or quantify.

Risks Related to Our Business and Our Industry

If we fail to estimate, price for and manage our medical costs or set benefit designs in an effective manner, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our products depends in large part on our ability to predict, price for and effectively manage medical costs. Our Optum Health business also enters into fully accountable value-based arrangements with payers. Premium revenues from risk-based products comprise nearly 80% of our total consolidated revenues. If we fail to predict accurately, or effectively price for or manage, the costs of providing care under risk-based arrangements, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of competitive provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies and Medicaid contracts is typically based on a fixed monthly rate per individual or family served for a 12-month period and is generally priced one to six months before the contract commences. Our revenue on certain Medicare policies is based on bids submitted to CMS in June of the year before the contract year. Our premium revenue on fully accountable value-based care products at Optum Health is typically based on a fixed monthly rate per individual served. Although we base the commercial, Medicaid and value-based premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, costs to deliver care, large-scale medical emergencies, the potential effects of climate change, pandemics, the introduction of new or costly drugs, treatments and technology, new treatment guidelines, newly mandated benefits or other regulatory changes and insured population characteristics. For Optum Health's fully accountable value-based care, our inability to provide higher-quality outcomes and better experiences at lower costs or our inability to integrate our care delivery models could impact our results of operations, financial positions and cash flows. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results.

In addition, the financial results we report for any particular period include estimates of costs incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove inaccurate, our results of operations could be materially and adversely affected.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our business depends on the integrity and timeliness of the data we use to serve our members, customers and health care professionals and to operate our business. If the data we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could experience failures in our health, wellness and information technology products; lose existing customers; have difficulty attracting new customers; experience problems in determining medical cost estimates and establishing appropriate pricing; have difficulty preventing, detecting and controlling fraud; have disputes with customers, physicians and other health care professionals; become subject to regulatory sanctions, penalties, investigations or audits; incur increases in operating expenses; or suffer other adverse consequences.

The volume of health care data generated, and the uses of data, including electronic health records, are rapidly expanding. Our ability to implement new and innovative services, automate and deploy new technologies to simplify administrative processes and clinical decision making, price our products and services adequately, provide effective service to our customers and consumers in an efficient and uninterrupted fashion, provide timely payments to care providers, and report accurately our results of operations depends on the integrity of the data in our information systems. In addition, connectivity among technologies is becoming increasingly important and recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences.

We periodically consolidate, integrate, upgrade and expand our information systems' capabilities as a result of technology initiatives, recently enacted regulations, changes in our system platforms and integration of new business acquisitions. Our process of consolidating the number of systems we operate, upgrading and expanding our information systems' capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology may not be successful. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install software products which may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to health data and the health information technology market may alter the competitive landscape or present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we or third parties we rely on sustain cyber-attacks or other privacy or data security incidents resulting in security breaches disrupting our operations or resulting in the unintended dissemination of protected personal information or proprietary or confidential information, we could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences.

We routinely process, store and transmit large amounts of data in our operations, including protected personal information subject to privacy, security or data breach notification laws, as well as proprietary or confidential information relating to our business or third parties. Some of the data we process, store and transmit may be outside of the United States due to our information technology systems and international business operations. We are regularly the target of attempted cyber-attacks and other security threats and may be subject to breaches of the information technology systems we use. We have programs in place to detect, contain and respond to data security incidents and provide employee awareness training regarding phishing, malware and other cyber risks to protect against cyber risks and security breaches. However, because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and are increasing in sophistication, we may be unable to anticipate these techniques, detect breaches for long periods of time or implement adequate preventive measures. Experienced computer programmers and hackers may be able to penetrate our security controls and access, misappropriate or otherwise compromise protected personal information or proprietary or confidential information or that of third parties, create system disruptions or cause system shutdowns, negatively affecting our operations. They also may be able to develop and deploy viruses, worms and other malicious software programs attacking our systems or otherwise exploit any security vulnerabilities. Hardware, software, or applications we develop or procure from third parties may contain defects in design or manufacture or other problems which could unexpectedly compromise information security. Our facilities and services may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; financial fraud schemes; misplaced or lost data; human error; malicious social engineering; or other events which could negatively affect our systems, our customers' data, proprietary or confidential information relating to our business or third parties, or our operations. Moreover, there has been an increase in new financial fraud schemes and ransomware attacks on large companies, whereby cybercriminals install malicious software preventing users or the enterprise from accessing computer files, systems or networks and demand payment of a ransom for return of access. In addition, there may be a heightened vulnerability due to the lack of physical supervision and on-site infrastructure for remote workforce operations. In certain circumstances we may rely on third-party vendors to process, store and transmit large amounts of data for our business whose operations are subject to similar risks.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be material. We have business continuation and resiliency plans which are maintained, updated and tested regularly in an effort to ensure successful containment and remediation of potential disruptions or cyber events. In the event that our remediation efforts may not be successful, it could result in interruptions, delays, or cessation of service and loss of existing or potential customers. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information, proprietary information or confidential information about us or our customers or other third parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, result in litigation and liability, including regulatory penalties, for us, damage our brand and reputation, or otherwise harm our business.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses face significant competition in all of the geographic markets in which we operate. In particular geographies or product segments, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; lower profit margin or financial return expectations; or other factors which give such competitors a competitive advantage. Our competitive position may also be adversely affected by significant merger and acquisition activity in the industries in which we operate, both among our competitors and suppliers. Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability.

In addition, our success in the health care marketplace depends on our ability to develop and deliver innovative and potentially disruptive products and services to satisfy evolving market demands. If we do not continue to innovate and provide products and services, which are useful and relevant to health care payers, consumers and our customers, we may not remain competitive and risk losing market share to existing competitors and disruptive new market entrants. For example, new direct-to-consumer business models from competing businesses may make it more difficult for us to directly engage consumers in the selection and management of their health care benefits and health care usage. We may face challenges from new technologies and market entrants which could affect our existing relationship with health plan enrollees in these areas. Any failure by us to continue to develop innovative care models, including accelerating the transition of care to value-based models achieving higher quality outcomes and better experiences at lower costs and expanding access to virtual and in-home care, could result in competitive disadvantages and loss of market share. Additionally, our competitive position could be adversely affected by a failure to develop satisfactory data and analytics capabilities or provide services focused on these capabilities to our clients. Our business, results of operations, financial position and cash flows also could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services demonstrating value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products. The expected resumption of Medicaid redeterminations may also impact our ability to maintain market share if we are unable to retain or add new consumers to other benefit offerings.

If we fail to develop and maintain satisfactory relationships with health care payers, physicians, hospitals and other service providers, our business could be materially and adversely affected.

We depend substantially on our continued ability to contract with health care payers (as a service provider to those payers), as well as physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and other service providers at competitive prices. If we fail to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, it could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes, which may be costly, divert management's attention from our operations and result in negative publicity.

In any particular market, physicians and health care providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher medical costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician and hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies which could diminish our bargaining power. In addition, Accountable Care Organizations (ACOs); physician group management services organizations (which aggregate physician practices for administrative efficiency); and other organizational structures adopted by physicians, hospitals and other care providers may change the way in which these providers do business with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our business, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way we price our products and estimate our costs, which might require us to incur costs to

change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

Our health care benefits businesses have risk-based arrangements with some physicians, hospitals and other health care providers. These arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent a risk-based health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the arrangement, we may be held responsible for unpaid health care claims which should have been the responsibility of the health care provider and for which we have already paid the provider. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with which we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In some instances, those providers may dispute the payment for these services and may institute litigation or arbitration.

The success of some of our businesses, including Optum Health and UnitedHealthcare Employer & Individual's international operations, depends on maintaining satisfactory relationships with physicians as our employees, independent contractors or joint venture partners. The physicians who practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. We face and will likely continue to face heightened competition to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with competitors of UnitedHealthcare. Our businesses could suffer if our affiliated physician organizations fail to maintain relationships with these companies, or fail to adequately price their contracts with these third-party payers.

Further, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and certain health care providers are customers of our Optum businesses. Physicians also provide medical services at facilities owned by our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

We are routinely subject to various legal actions, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

We are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. Any failure by us to adhere to the laws and regulations applicable to our businesses could subject us to civil and criminal penalties.

Legal actions to which we are a party have included or in the future could include matters related to health care benefits coverage and payment of claims (including disputes with enrollees, customers and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims (including claims related to the delivery of health care services, such as medical malpractice by staff at our affiliates' facilities, or by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks, including as a result of a failure to adhere to applicable clinical, quality and/or patient safety standards), antitrust claims (including as a result of changes in the enforcement of antitrust laws), whistleblower claims (including claims under the False Claims Act or similar statutes), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. In addition, certain of our pharmacy services operations are subject to clinical quality, patient safety and other risks inherent in the dispensing, packaging and

distribution of drugs, including claims related to purported dispensing and other operational errors. We may also be party to certain class action lawsuits brought by health care professional groups and consumers. We operate in jurisdictions outside of the United States where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others.

We are largely self-insured with regard to litigation risks, including claims of medical malpractice against our affiliated physicians and us. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible the level of actual losses will significantly exceed the liabilities recorded. Additionally, physicians and other healthcare providers have become subject to an increasing number of legal actions alleging medical malpractice and general professional liabilities. Even in states that have imposed caps on damages for such actions, litigants are seeking recoveries under new theories of liability that might not be subject to the caps on damages. These actions involve significant defense costs and could result in substantial monetary damages or damage to our reputation.

We cannot predict the outcome of significant legal actions in which we are involved. We incur expenses to resolve these matters and current and future legal actions could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. Moreover, certain legal actions could result in adverse publicity which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in some markets and businesses.

If we fail to successfully manage our strategic alliances, to complete, manage or integrate acquisitions and other significant strategic transactions or relationships domestically or outside the United States it could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated, which in turn could adversely impact our reputation, business and results of operations. Further, governmental actions, such as actions by the FTC or DOJ, may affect our ability to complete our merger and acquisition transactions, which could adversely affect our future growth. If we fail to identify and successfully complete transactions to meet our strategic objectives, we may be required to expend resources to develop products and technology internally, be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows.

Successful acquisitions are also dependent on effectively integrating the acquired business into our existing operations, including our internal control environment and culture, or otherwise leveraging its operations which may present challenges different from those presented by organic growth and may be difficult for us to manage. In addition, even with appropriate diligence, pre-acquisition practices of an acquired business may expose us to legal challenges and investigations. For example, in January 2021, an indictment for alleged violations of antitrust laws was issued by the DOJ against our subsidiary, Surgical Care Affiliates (SCA), based on conduct alleged to have begun more than five years prior to our acquisition of SCA. We are vigorously defending this lawsuit, but if SCA is found liable, we may be subject to criminal fines or reputational harm. If we cannot successfully integrate our acquired businesses and realize contemplated revenue growth opportunities, cost savings and other synergies, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we expand and operate our business outside of the United States, we are presented with challenges differing from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, languages, business, labor and cultural practices and regulatory environments. Adapting to these challenges could require us to devote significant senior management attention and other resources to the acquired businesses before we realize anticipated synergies or other benefits

from those businesses. These challenges vary widely by country and, outside of the United States, may include political instability, government intervention, discriminatory regulation and currency exchange controls or other restrictions, which could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate, or converting local currencies we hold into U.S. dollars or other currencies. If we are unable to manage successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our shareholders' equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

We are subject to risks associated with public health crises arising from large-scale medical emergencies, pandemics, natural disasters and other extreme events, which have and could have an adverse effect on our business, results of operations, financial condition and financial performance.

Large-scale medical emergencies, pandemics (such as COVID-19) and other extreme events could result in public health crises or otherwise have a material adverse effect on our business operations, cash flows, financial conditions and results of operations. For example, disruptions in public and private infrastructure resulting from such events could increase our operating costs and ability to provide services to our clients and customers. Additionally, as a result of these events, the premiums and fees we charge may not be sufficient to cover our medical and administrative costs, deferred medical care could be sought in future periods at potentially higher acuity levels, we could experience reduced demand for our services, our clinical and non-clinical workforce could be impacted resulting in reduced capacity to handle demand for care or otherwise impact our business operations. For example, COVID-19 has materially impacted our results of operations in previous periods. Public health crises arising from natural disasters, such as wildfires, hurricanes, and snowstorms, or effects of climate change could impact our business operations and result in increased medical care costs. Government enaction of emergency powers in response to public health crises could disrupt our business operations, including by restricting pharmaceuticals or other supplies, and could increase the risk of shortages of necessary items.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through nonexclusive producers and consultants and we compete for their services and allegiance. Our sales could be materially and adversely affected if we are unable to attract, retain and support independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commission levels.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. Unfavorable economic conditions also have caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in people served and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retroactively to apply to payments already negotiated or received from the government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on

health insurance and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment could also adversely impact the financial position of hospitals and other care providers which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, hospitals, care providers, employers and others which could, in turn, materially and adversely affect Optum's financial results.

Our failure to attract, develop, retain, and manage the succession of key employees and executives could adversely affect our business, results of operations and future performance.

We are dependent on our ability to attract, develop and retain qualified employees and executives, including those with diverse backgrounds, experiences and skills, to operate and expand our business. If we are unable to attract, develop, retain and effectively manage the development and succession plans for key employees and executives, our business, results of operations and future performance could be adversely affected. Experienced and highly skilled employees and executives in the health care and technology industries are in high demand and the market for their services is extremely competitive. We may have difficulty in replacing key executives because of the limited number of qualified individuals in these industries with the breadth of skills and experience required to operate and successfully expand our business. Adverse changes to our corporate culture, which seeks to foster integrity, compassion, relationships, innovation and performance, could harm our business operations and our ability to retain key employees and executives. While we have development and succession plans in place for our key employees and executives, these plans do not guarantee that the services of our key employees and executives will continue to be available to us.

Our investment portfolio may suffer losses which could adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities which constitute the vast majority of the fair value of our investments as of December 31, 2022. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily issuers of our investments in corporate and municipal bonds), could reduce our investment income and require us to write down the value of our investments which could adversely affect our profitability and equity.

Our investments may not produce total positive returns and we may sell investments at prices which are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial or market conditions, illiquidity or otherwise, could have an adverse effect on our equity. In addition, if it should become necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have an adverse effect on our results of operations and the capital position of our regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, equity and credit ratings could be materially and adversely affected.

As of December 31, 2022, our goodwill and other intangible assets had a carrying value of $108 billion, representing 44% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses we acquire perform in a manner inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and equity in the period in which the impairment occurs. A material decrease in equity could, in turn, adversely affect our credit ratings.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees and third parties, and our trademarks, trade secrets, copyrights and patents to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, and we expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this industry segment grows. Such litigation and misappropriation of our proprietary information could hinder our ability to market and sell products and services which could materially and adversely affect our results of operations, financial position and cash flows.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength and debt ratings by nationally recognized statistical rating organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used by customers and creditors. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. We may not be able to maintain our current credit ratings in the future. Any downgrades in our credit ratings could materially increase our costs of or ability to access funds in the debt capital markets and otherwise materially increase our operating costs.

Risks Related to the Regulation of Our Business

Our business activities in the United States and other countries are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations and some of our activities may be subject to other health care-related regulations and requirements, including regulations and licensure requirements related to PPOs, MCOs, UR and TPAs. Under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies which write the same line or similar lines of business. Any such assessment could expose our insurance entities and other insurers to the risk they would be required to pay a portion of an impaired or insolvent insurance company's claims through state guaranty associations.

Certain of our businesses provide products or services to government agencies. For example, some of our Optum and UnitedHealthcare businesses hold government contracts or provide services related to government contracts and are subject to U.S. federal and state and non-U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims and other laws and regulations governing government contractors and the use of government funds. Our relationships with these government agencies are subject to the terms of our contracts with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies which might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of engagements, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations distinct from those faced by our insurance and HMO subsidiaries, some of which could impact our relationships with physicians, hospitals and customers. These regulations include state telemedicine regulations; debt collection laws; banking regulations; distributor and producer licensing requirements; state corporate practice of medicine doctrines; fee-splitting rules; and health care facility licensure and certificate of need

requirements. These risks and uncertainties may materially and adversely affect our ability to market or provide our products and services, or to achieve targeted operating margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our businesses and interpretations of those laws and rules are subject to frequent change. For example, legislative, administrative and public policy changes to the ACA have been and likely will continue to be considered, and we cannot predict if the ACA will be further modified. Litigation challenges have been brought seeking to invalidate the ACA in whole or in part and future litigation challenges are possible. Further, the integration of entities we acquire into our businesses may affect the way in which existing laws and rules apply to us, including by subjecting us to laws and rules which did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our businesses could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We also must obtain and maintain regulatory approvals to market many of our products and services, increase prices for certain regulated products and services and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on proposed rate increases to HHS on many of our products for monitoring purposes. Geographic and product expansions of our businesses may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

We currently operate outside of the United States and in the future may acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services or to do so at targeted operating margins, which may have a material adverse effect on our business, financial condition and results of operations. Non-U.S. regulatory regimes, which vary by jurisdiction, encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers). For example, our UnitedHealthcare Employer & Individual international business subjects us to Brazilian laws and regulations affecting hospitals, managed care and insurance industries and to regulation by Brazilian regulators, including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, while our Banmédica business is subject to Chilean, Colombian and Peruvian laws, regulations and regulators applicable to hospitals and private insurance. Any international regulator may take an approach to the interpretation, implementation and enforcement of industry regulations which could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws regulating the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

The health care industry is regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations which could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive substantial revenues from these programs. Certain of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation

methodologies, or termination of the contract at the option of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes which may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example, CMS has in the past reduced or frozen Medicare Advantage benchmarks and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit. States have also made changes in rates and reimbursements for Medicaid members and audits can result in unexpected recoupments.

Under the Medicaid managed care program, state Medicaid agencies solicit bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members who were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs and other factors. If any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, implementation of material program or policy changes after our bid submission, or submission by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs we participate in are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of the ACA, CMS has a system providing various quality bonus payments to Medicare Advantage plans meeting certain quality star ratings at the individual plan or local contract level. The star rating system considers various measures adopted by CMS, including, among others, quality of care, preventive services, chronic illness management, handling of appeals and customer satisfaction. Plans must have a rating of four stars or higher to qualify for bonus payments. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits our plans can offer, which could materially and adversely affect the marketability of our plans, number of people we serve, and our results of operations, financial position and cash flows. Any changes in standards or care delivery models applying to government health care programs, including Medicare and Medicaid, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjustment of monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers for Medicare Advantage plans, as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs forecasted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically

perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Certain of our local plans have been selected for such audits, which in the past have resulted and in the future could result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS.

We have been involved, and in the future may become involved in routine, regular and special governmental investigations, audits, reviews and assessments. Such investigations, audits, reviews or assessments sometimes arise out of, or prompt claims by private litigants or whistleblowers who, among other allegations, may claim we failed to disclose certain business practices or, as a government contractor, submitted false or erroneous claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which have resulted in, and in the future could result in, adverse publicity, the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

Our pharmacy care services businesses face regulatory and operational risks and uncertainties which may differ from the risks of our other businesses.

We provide pharmacy care services through our Optum Rx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback, beneficiary inducement and other laws governing the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. In addition, federal and state legislatures regularly consider new regulations for the industry which could materially affect current industry practices, including potential new legislation and regulations regarding the receipt or disclosure of rebates and other fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies. Further, various governmental agencies have conducted and continue to conduct investigations and studies into certain PBM practices, which have resulted and may result in PBMs agreeing to civil penalties, including the payment of money and entry into corporate integrity agreements, or could materially and adversely impact the PBM business model. As a provider of pharmacy benefit management services, Optum Rx is also subject to an increasing number of licensure, registration and other laws and accreditation standards. Optum Rx conducts business through home delivery, specialty and compounding pharmacies, pharmacies located in community mental health centers and home infusion, which subjects it to extensive federal, state and local laws and regulations, including those of the DEA and individual state controlled substance authorities, the Food and Drug Administration (FDA) and Boards of Pharmacy.

We could face potential claims in connection with purported errors by our home delivery, specialty or compounding or clinic-based pharmacies or the provision of home infusion services, claims related to the inherent risks in the packaging and distribution of pharmaceuticals and other health care products. Disruptions from any of our home delivery, specialty pharmacy or home infusion services could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our pharmacy care services businesses provide services to sponsors of health benefit plans subject to ERISA. A private party or the DOL, which is the agency that enforces ERISA, could assert the fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy care services businesses even where those businesses are not contractually obligated to assume fiduciary obligations. If a court were to determine such fiduciary obligations apply, we could be subject to claims for breaches of fiduciary obligations or claims we entered into certain prohibited transactions.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, including with respect to third-party service providers utilizing protected personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of protected personal information are regulated at the federal, state, international and industry levels and addressed in requirements imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws,

regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations.

Internationally, many of the jurisdictions in which we operate have established their own data security and privacy legal framework with which we or our customers must comply. We expect there will continue to be new proposed laws, regulations and industry standards concerning privacy, data protection and information security in the European Union, Brazil, Chile, India and other jurisdictions, and we cannot yet determine the impacts such future laws, regulations and standards may have on our businesses or the businesses of our customers. For example, the European Union's General Data Protection Regulation (GDPR) imposes more stringent European Union data protection requirements on us or our customers, and prescribes greater penalties for noncompliance. Brazilian privacy legislation, similar in certain respects to GDPR, took effect in September 2020.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard designed to protect payment card account data.

HIPAA requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain protected personal information in order to provide services to these customers. HHS administers its audit program to assess HIPAA compliance efforts by covered entities and business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, we maintain a database of administrative and clinical data statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of protected personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business and, among other consequences, could subject us to mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents, and material fines, penalties and litigation awards. Any of these consequences could have a material and adverse effect on our results of operations, financial position and cash flows.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our results of operations, financial position and cash flows.

Because we operate as a holding company, we are dependent on dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by state departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily on the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries exceeding specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flows could be materially and adversely affected.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

We own and lease real properties to support our business operations in the United States and other countries. Our reportable segments use these facilities for their respective business purposes, and we believe the current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions "Legal Matters" and "Governmental Investigations, Audits and Reviews" in Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data"

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2023, there were 10,260 holders of record of our common stock.

DIVIDEND POLICY

In June 2022, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of $6.60 compared to $5.80 per share, which the Company had paid since June 2021. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

Issuer Purchases of Equity Securities (a)
Fourth Quarter 2022

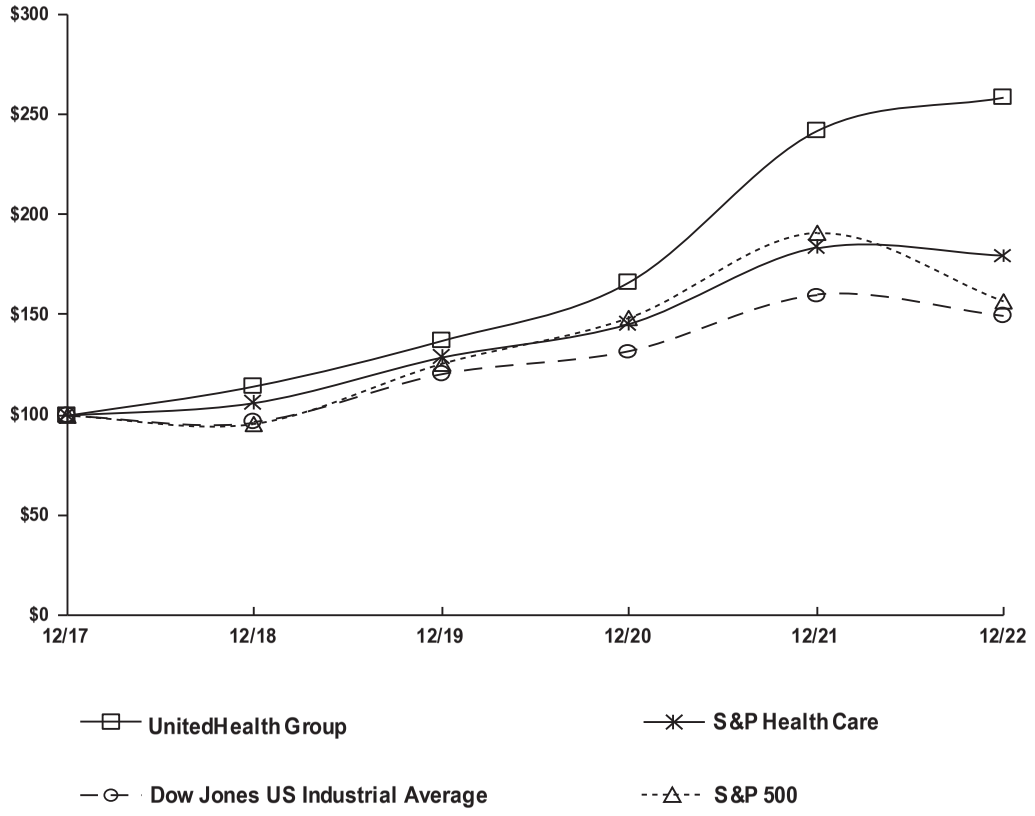
For the Month Ended	Total Number of Shares Purchased	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares That May Yet Be Purchased Under The Plans or Programs
	(in millions)		(in millions)	(in millions)
October 31, 2022	0.7	$ 519.51	0.7	32.3
November 30, 2022	0.6	533.81	0.6	31.7
December 31, 2022	0.6	533.56	0.6	31.1
Total	1.9	$ 528.87	1.9	

(a) In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. In June 2018, the Board of Directors renewed our share repurchase program with an authorization to repurchase up to 100 million shares of our common stock in open market purchases or other types of transactions (including prepaid or structured repurchase programs). There is no established expiration date for the program.

PERFORMANCE GRAPH

The following performance graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P Health Care Index, the Dow Jones US Industrial Average Index and the S&P 500 Index for the five-year period ended December 31, 2022. The comparisons assume the investment of $100 on December 31, 2017 in our common stock and in each index, and dividends were reinvested when paid.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN
Among UnitedHealth Group, the S&P Health Care Index,
the Dow Jones US Industrial Average Index and the S&P 500 Index



	12/17	12/18	12/19	12/20	12/21	12/22
UnitedHealth Group	$ 100.00	$ 114.52	$ 137.41	$ 166.55	$ 241.85	$ 258.65
S&P Health Care Index	100.00	106.47	128.64	145.93	184.07	180.47
Dow Jones US Industrial Average	100.00	96.52	120.98	132.75	160.55	149.53
S&P 500 Index	100.00	95.62	125.72	148.85	191.58	156.89

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. [Reserved]

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Part II Item 8, "Financial Statements and Supplementary Data." Readers are cautioned the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties which may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

Discussions of year-over-year comparisons between 2021 and 2020 are not included in this Form 10-K and can be found in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" of the Company's Form 10-K for the fiscal year ended December 31, 2021.

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health care company with a mission to help people live healthier lives and help make the health system work better for everyone. Our two complementary businesses—Optum and UnitedHealthcare—are driven by this unified mission and vision to improve health care access, affordability, experiences and outcomes for the individuals and organizations we are privileged to serve.

We have four reportable segments across our two business platforms, Optum and UnitedHealthcare:

- Optum Health;
- Optum Insight;
- Optum Rx; and
- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 14 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Business Trends

Our businesses participate in the United States, South America and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises 18% of gross domestic product (GDP). We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macroeconomic conditions, which could impact our results of operations, including our continued efforts to control health care costs.

Pricing Trends. To price our health care benefits, products and services, we start with our view of expected future costs, including inflation and labor market dynamics. We frequently evaluate and adjust our approach in each of the local markets we serve, considering relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum medical loss ratio (MLR) thresholds and similar revenue adjustments. We will continue seeking to balance growth and profitability across all these dimensions.

The commercial risk market remains highly competitive in the small group, large group and individual segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs.

Medicare Advantage funding continues to be pressured, as discussed below in "Regulatory Trends and Uncertainties."

In Medicaid, we believe the payment rate environment creates the risk of continued downward pressure on Medicaid margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We continue to advocate for actuarially sound rates commensurate with our medical cost trends and we remain dedicated to partnering with those states that are committed to the long-term viability of their programs.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs; care activity; and prescription drug costs. We endeavor to mitigate those increases by engaging physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high-quality, affordable care.

Medicaid Redeterminations. In December 2022, Congress passed the 2023 Omnibus Appropriations bill that allows states to resume Medicaid redeterminations beginning in April 2023. Redeterminations will result in a decline in people served through our Medicaid business and an expected increase in people served through our commercial and exchange-based offerings as we endeavor to ensure that people have continued access to benefits.

Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality and patient experience, improve the health of populations and reduce costs. We are working to accelerate this vision through the innovation and integration of our care delivery models including in clinic, in-home, behavioral and virtual care, and by using our data and analytics to provide clinicians with the necessary information in order to provide the best possible care in the most cost efficient setting. We continue to see a greater number of people enrolled in fully accountable value-based plans rewarding high-quality, affordable care and fostering collaboration.

This trend is creating needs for health management services which can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe provide growth opportunities for our Optum business platform.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to regulatory matters. For additional information regarding regulatory trends and uncertainties, see Part I, Item 1 "Business — Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates. Medicare Advantage rate notices over the years have at times resulted in industry base rates well below industry forward medical trend. For example, the February 2023 Advance Notice for 2024 rates would result in an industry base rate decrease, well short of what is an increasing industry forward medical cost trend, creating continued pressure in the Medicare Advantage program. Further, proposed substantial revisions to the risk adjustment model, which serves to adjust rates to reflect a patient's health status and care resource needs, would result in reduced funding and benefits for people, especially those with some of the greatest health and social challenges.

As a result of ongoing Medicare funding pressures, there are adjustments we can make to partially offset these rate pressures and reductions for a particular period. For example, we can seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust member benefits and implement or increase the member premiums supplementing the monthly payments we receive from the government. Additionally, we decide annually on a county-by-county basis where we will offer Medicare Advantage plans.

SELECTED OPERATING PERFORMANCE ITEMS

The following represents a summary of select 2022 year-over-year operating comparisons to 2021.

- Consolidated revenues increased by 13%, UnitedHealthcare revenues increased 12% and Optum revenues grew 17%.
- UnitedHealthcare served nearly 1.1 million more people, led by growth in community-based and senior offerings.
- Earnings from operations increased by 19%, including an increase of 20% at UnitedHealthcare and 17% at Optum.
- Diluted earnings per common share increased 17% to $21.18.
- Cash flows from operations were $26.2 billion.
- Return on equity was 27.2%.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31, 2022	2021	2020	Change 2022 vs. 2021	
Revenues:					
Premiums	$ 257,157	$ 226,233	$ 201,478	$ 30,924	14%
Products	37,424	34,437	34,145	2,987	9
Services	27,551	24,603	20,016	2,948	12
Investment and other income	2,030	2,324	1,502	(294)	(13)
Total revenues	324,162	287,597	257,141	36,565	13
Operating costs:					
Medical costs	210,842	186,911	159,396	23,931	13
Operating costs	47,782	42,579	41,704	5,203	12
Cost of products sold	33,703	31,034	30,745	2,669	9
Depreciation and amortization	3,400	3,103	2,891	297	10
Total operating costs	295,727	263,627	234,736	32,100	12
Earnings from operations	28,435	23,970	22,405	4,465	19
Interest expense	(2,092)	(1,660)	(1,663)	(432)	26
Earnings before income taxes	26,343	22,310	20,742	4,033	18
Provision for income taxes	(5,704)	(4,578)	(4,973)	(1,126)	25
Net earnings	20,639	17,732	15,769	2,907	16
Earnings attributable to noncontrolling interests	(519)	(447)	(366)	(72)	16
Net earnings attributable to UnitedHealth Group common shareholders	$ 20,120	$ 17,285	$ 15,403	$ 2,835	16%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 21.18	$ 18.08	$ 16.03	$ 3.10	17%
Medical care ratio (a)	82.0%	82.6%	79.1%	(0.6)%	
Operating cost ratio	14.7	14.8	16.2	(0.1)	
Operating margin	8.8	8.3	8.7	0.5	
Tax rate	21.7	20.5	24.0	1.2	
Net earnings margin (b)	6.2	6.0	6.0	0.2	
Return on equity (c)	27.2%	25.2%	24.9%	2.0%	

(a) Medical care ratio (MCR) is calculated as medical costs divided by premium revenue.

(b) Net earnings margin attributable to UnitedHealth Group common shareholders.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

2022 RESULTS OF OPERATIONS COMPARED TO 2021 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues were primarily driven by growth in the number of people served through Medicare Advantage and Medicaid, pricing trends and growth across the Optum businesses.

Medical Costs and MCR

Medical costs increased due to growth in people served. The MCR decreased due to COVID-19 effects, partially offset by decreased prior years favorable development and business mix.

Operating Cost Ratio

The operating cost ratio decreased primarily due to productivity gains, partially offset by investments and business mix.

Reportable Segments

See Note 14 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for more information on our segments. We utilize various metrics to evaluate and manage our reportable segments, including individuals served by UnitedHealthcare by major market segment and funding arrangement, people served by Optum Health and adjusted scripts for Optum Rx. These metrics are the main drivers of revenue, earnings and cash flows at each business. The metrics also allow management and investors to evaluate and understand business mix, including the level and scope of services provided to people and pricing trends when comparing the metrics to revenue by segment.

The following table presents a summary of the reportable segment financial information:

	For the Years Ended December 31,			Change	
(in millions, except percentages)	2022	2021	2020	2022 vs. 2021	
Revenues					
UnitedHealthcare	$ 249,741	$ 222,899	$ 200,875	$ 26,842	12%
Optum Health	71,174	54,065	39,808	17,109	32
Optum Insight	14,581	12,199	10,802	2,382	20
Optum Rx	99,773	91,314	87,498	8,459	9
Optum eliminations	(2,760)	(2,013)	(1,800)	(747)	37
Optum	182,768	155,565	136,308	27,203	17
Eliminations	(108,347)	(90,867)	(80,042)	(17,480)	19
Consolidated revenues	$ 324,162	$ 287,597	$ 257,141	$ 36,565	13%
Earnings from operations					
UnitedHealthcare	$ 14,379	$ 11,975	$ 12,359	$ 2,404	20%
Optum Health	6,032	4,462	3,434	1,570	35
Optum Insight	3,588	3,398	2,725	190	6
Optum Rx	4,436	4,135	3,887	301	7
Optum	14,056	11,995	10,046	2,061	17
Consolidated earnings from operations	$ 28,435	$ 23,970	$ 22,405	$ 4,465	19%
Operating margin					
UnitedHealthcare	5.8%	5.4%	6.2%	0.4%	
Optum Health	8.5	8.3	8.6	0.2	
Optum Insight	24.6	27.9	25.2	(3.3)	
Optum Rx	4.4	4.5	4.4	(0.1)	
Optum	7.7	7.7	7.4	—	
Consolidated operating margin	8.8%	8.3%	8.7%	0.5%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	For the Years Ended December 31, 2022	2021	2020	Change 2022 vs. 2021	
UnitedHealthcare Employer & Individual — Domestic	$ 63,599	$ 60,023	$ 55,872	$ 3,576	6%
UnitedHealthcare Employer & Individual — Global (a)	8,668	8,345	7,752	323	4
UnitedHealthcare Employer & Individual — Total (a)	72,267	68,368	63,624	3,899	6
UnitedHealthcare Medicare & Retirement	113,671	100,552	90,764	13,119	13
UnitedHealthcare Community & State	63,803	53,979	46,487	9,824	18
Total UnitedHealthcare revenues	$ 249,741	$ 222,899	$ 200,875	$ 26,842	12%

(a) On January 1, 2022, we realigned our operating segments to combine UnitedHealthcare Global and UnitedHealthcare Employer & Individual.

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31, 2022	2021	2020	Change 2022 vs. 2021	
Commercial — domestic:					
Risk-based	8,045	7,985	7,910	60	1%
Fee-based	18,640	18,595	18,310	45	—
Total commercial — domestic	26,685	26,580	26,220	105	—
Medicare Advantage	7,105	6,490	5,710	615	9
Medicaid	8,170	7,655	6,620	515	7
Medicare Supplement (Standardized)	4,375	4,395	4,460	(20)	—
Total community and senior	19,650	18,540	16,790	1,110	6
Total UnitedHealthcare — domestic medical	46,335	45,120	43,010	1,215	3
Commercial — global	5,360	5,510	5,425	(150)	(3)
Total UnitedHealthcare — medical	51,695	50,630	48,435	1,065	2%
Supplemental Data:					
Medicare Part D stand-alone	3,295	3,700	4,045	(405)	(11)%

Medicare Advantage increased due to growth in people served through individual and group Medicare Advantage plans. The increase in people served through Medicaid was primarily driven by states continuing to ease redetermination requirements and growth in people served through Dual Special Needs Plans.

UnitedHealthcare's revenues increased due to growth in the number of people served through Medicare Advantage and Medicaid. Earnings from operations increased due to growth in people served and COVID-19 effects, partially offset by decreased prior years favorable development.

Optum

Total revenues and earnings from operations increased due to growth across the Optum businesses. The results by segment were as follows:

Optum Health

Revenues at Optum Health increased primarily due to organic growth in patients served under value-based care arrangements and business combinations. Earnings from operations increased due to organic growth in the number of people served under

value-based care arrangements, cost management initiatives, asset dispositions and COVID-19 effects. Optum Health served approximately 102 million people as of December 31, 2022 compared to 100 million people as of December 31, 2021.

Optum Insight

Revenues and earnings from operations at Optum Insight increased due to growth in technology and managed services, with managed services revenue growth driven by business combinations and new health system partnerships.

Optum Rx

Revenues and earnings from operations at Optum Rx increased due to higher script volumes from growth in people served, increased utilization and organic growth in pharmacy care services, including community health, specialty and home delivery pharmacies. Earnings from operations also increased as a result of continued supply chain management initiatives. Optum Rx fulfilled 1,438 million and 1,368 million adjusted scripts in 2022 and 2021, respectively.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to, among other things, minimum levels of statutory capital, as defined by their respective jurisdictions, and restrictions on the timing and amount of dividends paid to their parent companies.

Our U.S. regulated subsidiaries paid their parent companies dividends of $8.8 billion and $8.0 billion in 2022 and 2021, respectively. See Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for further detail concerning our regulated subsidiary dividends.

Our nonregulated businesses also generate significant cash flows from operations available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt and return capital to our shareholders through dividends and repurchases of our common stock.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	For the Years Ended December 31, 2022	2021	2020	Change 2022 vs. 2021
Sources of cash:				
Cash provided by operating activities	$ 26,206	$ 22,343	$ 22,174	$ 3,863
Issuances of long-term debt and short-term borrowings, net of repayments	12,536	2,481	2,586	10,055
Proceeds from common share issuances	1,253	1,355	1,440	(102)
Customer funds administered	5,548	622	1,677	4,926
Cash received for dispositions	3,414	15	221	3,399
Total sources of cash	48,957	26,816	28,098	
Uses of cash:				
Cash paid for acquisitions, net of cash assumed	(21,458)	(4,821)	(7,139)	(16,637)
Cash dividends paid	(5,991)	(5,280)	(4,584)	(711)
Common share repurchases	(7,000)	(5,000)	(4,250)	(2,000)
Purchases of property, equipment and capitalized software	(2,802)	(2,454)	(2,051)	(348)
Purchases of investments, net of sales and maturities	(6,837)	(1,843)	(2,836)	(4,994)
Purchases of redeemable noncontrolling interests	(176)	(1,338)	—	1,162
Other	(2,737)	(1,564)	(1,186)	(1,173)
Total uses of cash	(47,001)	(22,300)	(22,046)	
Effect of exchange rate changes on cash and cash equivalents	34	(62)	(116)	96
Net increase in cash and cash equivalents	$ 1,990	$ 4,454	$ 5,936	$ (2,464)

2022 Cash Flows Compared to 2021 Cash Flows

Increased cash flows provided by operating activities were primarily driven by changes in working capital accounts and increased net earnings. Other significant changes in sources or uses of cash year-over-year included increased net issuances of long-term debt, customer funds administered, primarily driven by Medicare Part D timing and increased HSA deposits, cash received for dispositions and decreased purchases of redeemable noncontrolling interests, partially offset by increased cash paid for acquisitions, net purchases of investments and common stock repurchases.

Financial Condition

As of December 31, 2022, our cash, cash equivalent, available-for-sale debt securities and equity securities balances of $69.4 billion included $23.4 billion of cash and cash equivalents (of which $1.3 billion was available for general corporate use), $42.3 billion of debt securities and $3.7 billion of equity securities. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is fully supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 4.0 years and a weighted-average credit rating of “Double A” as of December 31, 2022. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

Cash Requirements. The Company’s cash requirements within the next twelve months include medical costs payable, accounts payable and accrued liabilities, short-term borrowings and current maturities of long-term debt, other current liabilities, and purchase commitments and other obligations. We expect the cash required to meet these obligations to be primarily generated

through cash flows from current operations; cash available for general corporate use; and the realization of current assets, such as accounts receivable.

Our long-term cash requirements under our various contractual obligations and commitments include:

- *Debt obligations.* See Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail of our long-term debt and the timing of expected future payments. Interest coupon payments are typically paid semi-annually.
- *Operating leases.* See Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail of our obligations and the timing of expected future payments.
- *Purchase and other obligations.* These include $5.6 billion, $2.9 billion of which is expected to be paid within the next twelve months, of fixed or minimum commitments under existing purchase obligations for goods and services, including agreements cancelable with the payment of an early termination penalty, and remaining capital commitments for venture capital funds and other funding commitments. These amounts exclude agreements cancelable without penalty and liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2022.
- *Other liabilities.* These include other long-term liabilities reflected in our Consolidated Balance Sheets as of December 31, 2022, including obligations associated with certain employee benefit programs, unrecognized tax benefits and various long-term liabilities, which have some inherent uncertainty in the timing of these payments.
- *Redeemable noncontrolling interests.* See Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail. We do not have any material expected redemptions in the next twelve months.

We expect the cash required to meet our long-term obligations to be primarily generated through future cash flows from operations. However, we also have the ability to generate cash to satisfy both our current and long-term requirements through the issuance of commercial paper, issuance of long-term debt, or drawing under our committed credit facilities or the ability to sell investments. We believe our capital resources are sufficient to meet future, short-term and long-term, liquidity needs.

Short-Term Borrowings. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of senior unsecured debt through independent broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 60%, subject to increase in certain circumstances set forth in the applicable credit agreement. As of December 31, 2022, our debt to debt-plus-shareholders' equity ratio, as defined and calculated under the credit facilities, was 38%.

Long-Term Debt. Periodically, we access capital markets to issue long-term debt for general corporate purposes, such as to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases. For more information on our debt, see Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8 "Financial Statements and Supplementary Data."

Credit Ratings. Our credit ratings as of December 31, 2022 were as follows:

	Moody's		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Positive	A+	Stable	A	Stable	A	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-1+	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. A significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. As of December 31, 2022, we had Board of Directors' authorization to purchase up to 31 million shares of our common stock. For more information on our share repurchase program, see Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Dividends. In June 2022, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of $6.60 compared to $5.80 per share. For more information on our dividend, see Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Pending Acquisitions. As of December 31, 2022, we have entered into agreements to acquire companies in the health care sector, most notably, LHC Group, Inc. (NASDAQ: LHCG), subject to regulatory approval and other customary closing conditions. The total anticipated capital required for these acquisitions, excluding the payoff of acquired indebtedness, is approximately $9 billion. We completed the acquisition of LHC Group, Inc. on February 22, 2023.

We do not have other significant contractual obligations or commitments requiring cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications and may include acquisitions.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates requiring management to make challenging, subjective or complex judgments, often because they must estimate the effects of matters inherently uncertain and may change in subsequent periods. Critical accounting estimates involve judgments and uncertainties which are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

Medical costs and medical costs payable include estimates of our obligations for medical care services rendered on behalf of consumers, but for which claims have either not yet been received or processed. Depending on the health care professional and type of service, the typical billing lag for services can be up to 90 days from the date of service. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service.

In each reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods. If the revised estimate of prior period medical costs is less than the previous estimate, we will decrease reported medical costs in the current period (favorable development). If the revised estimate of prior period medical costs is more than the previous estimate, we will increase reported medical costs in the current period (unfavorable development). Medical costs in 2022, 2021 and 2020 included favorable medical cost development related to prior years of $410 million, $1.7 billion and $880 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, for the most recent two months, we estimate claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period adjudicated by us at the date of estimation. Completion factors are the most significant factors we use in developing our medical costs payable estimates for periods prior to the most recent two months. Completion factors include judgments in relation to claim submissions such as the time from date of service

to claim receipt, claim levels and processing cycles, as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions), actual care activity incurred (which can be influenced by pandemics or seasonal illnesses, such as influenza), or our claim processing patterns are different than estimated, our reserve estimates may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2022:

Completion Factors (Decrease) Increase in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 765
(0.50)	508
(0.25)	254
0.25	(252)
0.50	(503)
0.75	(753)

Medical Cost Per Member Per Month Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent two months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design and a review of a broad set of health care utilization indicators. These factors include but are not limited to pharmacy utilization trends, inpatient hospital authorization data and seasonal and other incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as GDP growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates, including: our ability and practices to manage medical and pharmaceutical costs, changes in level and mix of services utilized; mix of benefits offered, including the impact of co-pays and deductibles; changes in medical practices; and catastrophes, epidemics and pandemics.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent two months as of December 31, 2022:

Medical Cost PMPM Quarterly Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 985
2	656
1	328
(1)	(328)
(2)	(656)
(3)	(985)

The completion factors and medical costs PMPM trend factors analyses above include outcomes considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2022; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2022 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2022 net earnings would have increased or decreased by approximately $215 million.

For more detail related to our medical cost estimates, see Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.”

Goodwill

We evaluate goodwill for impairment annually or more frequently when an event occurs or circumstances change indicating the carrying value may not be recoverable. When testing goodwill for impairment, we may first assess qualitative factors to determine if it is more likely than not the carrying value of a reporting unit exceeds its estimated fair value. During a qualitative analysis, we consider the impact of changes, if any, to the following factors: macroeconomic, industry and market factors; cost factors; changes in overall financial performance; and any other relevant events and uncertainties impacting a reporting unit. If our qualitative assessment indicates a goodwill impairment is more likely than not, we perform additional quantitative analyses. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing. For reporting units where a quantitative analysis is performed, we perform a test measuring the fair values of the reporting units and comparing them to their carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, an impairment is recognized for the difference, up to the carrying amount of goodwill.

We estimate the fair values of our reporting units using a discounted cash flow method which includes assumptions about a wide variety of internal and external factors. Significant assumptions used in the discounted cash flow method include financial projections of free cash flow, including revenue trends, medical costs trends, operating productivity, income taxes and capital levels; long-term growth rates for determining terminal value beyond the discretely forecasted periods; and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Financial projections and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. Our most significant estimate in the discount rate determinations involves our adjustments to the peer company weighted average costs of capital reflecting reporting unit-specific factors. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty. The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units' operations could cause these assumptions to change in the future. Additionally, as part of our quantitative impairment testing, we perform various sensitivity analyses on certain key assumptions, such as discount rates and cash flow projections to analyze the potential for a material impact. As of October 1, 2022, we completed our annual impairment tests for goodwill with all of our reporting units having fair values substantially in excess of their carrying values.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our Board of Directors. This policy limits the amounts which may be invested in any one issuer and generally limits our investments to U.S. government and agency securities, state and municipal securities and corporate debt obligations of investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups and other customers constituting our client base. As of December 31, 2022, there were no significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to changes in interest rates impacting our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, as well as foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real and Chilean peso.

As of December 31, 2022, we had $31 billion of financial assets on which the interest rates received vary with market interest rates, which may significantly impact our investment income. Also as of December 31, 2022, $16 billion of our financial liabilities, which include debt and deposit liabilities, were at interest rates which vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2022, $38 billion of our investments were fixed-rate debt securities and $43 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed-income market sectors and debt across maturities, as well as by matching a portion of our floating-rate assets and liabilities, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale debt securities are reported in comprehensive income.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of December 31, 2022 and 2021 on our investment income and interest expense per annum and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2022			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets	Fair Value of Financial Liabilities
2%	$ 629	$ 327	$ (3,390)	$ (7,365)
1	314	164	(1,746)	(4,002)
(1)	(314)	(135)	1,838	4,808
(2)	(629)	(266)	3,746	10,641

	December 31, 2021			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets	Fair Value of Financial Liabilities
2%	$ 499	$ 133	$ (3,080)	$ (8,664)
1	250	67	(1,564)	(4,723)
(1)	(85)	(7)	1,398	5,655
(2)	(85)	(7)	1,857	10,892

Note: The impact of hypothetical changes in interest rates may not reflect the full 100 or 200 basis point change on interest income and interest expense or on the fair value of financial assets and liabilities as the rates are assumed to not fall below zero.

We have an exposure to changes in the value of foreign currencies, primarily the Brazilian real and the Chilean peso, to the U.S. dollar in translation of UnitedHealthcare Employer & Individual's international business operating results at the average exchange rate over the accounting period, and assets and liabilities at the exchange rate at the end of the accounting period. The gains or losses resulting from translating foreign assets and liabilities into U.S. dollars are included in equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real or Chilean peso reduces the carrying value of the net assets denominated in those currencies. For example, as of December 31, 2022, a hypothetical 10% and 25% increase in the value of the U.S. dollar against those currencies would have caused a reduction in net assets of approximately $560 million and $1.2 billion, respectively. We manage exposure to foreign currency earnings risk primarily by conducting our international business operations in their functional currencies.

As of December 31, 2022, we had $3.7 billion of investments in equity securities, primarily consisting of investments in employee savings plan related investments, other venture investments and non-U.S. dollar fixed-income funds. Valuations in non-U.S. dollar funds are subject to foreign exchange rates.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2022 and 2021, the related consolidated statements of operations, comprehensive income, changes in equity and cash flows for each of the three years in the period ended December 31, 2022, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2022 and 2021, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2022, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2022, based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 24, 2023 expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matter

The critical audit matter communicated below is a matter arising from the current-period audit of the financial statements that was communicated or required to be communicated to the Audit and Finance Committee and that (1) relates to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the accounts or disclosures to which it relates.

Incurred but not Reported (IBNR) Claim Liability—Refer to Notes 2 and 7 to the financial statements.

Critical Audit Matter Description

Medical costs payable includes estimates of the Company's obligations for medical care services rendered on behalf of insured consumers, for which claims have either not yet been received or processed. These estimates are referred to as incurred but not reported (IBNR) claim liabilities. At December 31, 2022, the Company's IBNR balance was $20 billion. The Company develops IBNR estimates using an actuarial model that requires management to exercise certain judgments in developing its estimates. Judgments made by management include medical cost per member per month trend factors and completion factors,

which include assumptions over the time from date of service to claim receipt, the impact of actual care activity, and processing cycles.

We identified the IBNR claim liability as a critical audit matter because of the significant assumptions made by management in estimating the liability. This required complex auditor judgment, and an increased extent of effort, including the involvement of actuarial specialists in performing procedures to evaluate the reasonableness of management's methods, assumptions and judgments in developing the liability.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures included the following, among others:

- We tested the effectiveness of controls over management's estimate of the IBNR claim liability balance, including controls over the judgments in both the completion factors and the medical cost per member per month trend factors, as well as controls over the claims and membership data used in the estimation process.
- We tested the underlying claims and membership data and other information that served as the basis for the actuarial analysis, to test that the inputs to the actuarial estimate were complete and accurate.
- With the assistance of actuarial specialists, we evaluated the reasonableness of the actuarial methods and assumptions used by management to estimate the IBNR claim liability by:
    - Performing an overlay of the historical claims data used in management's current year model to the data used in prior periods to validate that there were no material changes to the claims data tested in prior periods.
    - Developing an independent estimate of the IBNR claim liability and comparing our estimate to management's estimate.
    - Performing a retrospective review comparing management's prior year estimate of IBNR to claims processed in 2022 with dates of service in 2021 or prior.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 24, 2023

We have served as the Company's auditor since 2002.

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2022	December 31, 2021
Assets		
Current assets:		
Cash and cash equivalents	$ 23,365	$ 21,375
Short-term investments	4,546	2,532
Accounts receivable, net of allowances of $877 and $954	17,681	14,216
Other current receivables, net of allowances of $1,433 and $993	12,769	13,866
Assets under management	4,087	4,449
Prepaid expenses and other current assets	6,621	5,320
Total current assets	69,069	61,758
Long-term investments	43,728	43,114
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $6,930 and $5,992	10,128	8,969
Goodwill	93,352	75,795
Other intangible assets, net of accumulated amortization of $6,137 and $5,636	14,401	10,044
Other assets	15,027	12,526
Total assets	$ 245,705	$ 212,206
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	$ 29,056	$ 24,483
Accounts payable and accrued liabilities	27,715	24,643
Short-term borrowings and current maturities of long-term debt	3,110	3,620
Unearned revenues	3,075	2,571
Other current liabilities	26,281	22,975
Total current liabilities	89,237	78,292
Long-term debt, less current maturities	54,513	42,383
Deferred income taxes	2,769	3,265
Other liabilities	12,839	11,787
Total liabilities	159,358	135,727
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	4,897	1,434
Equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 934 and 941 issued and outstanding	9	10
Retained earnings	86,156	77,134
Accumulated other comprehensive loss	(8,393)	(5,384)
Nonredeemable noncontrolling interests	3,678	3,285
Total equity	81,450	75,045
Total liabilities, redeemable noncontrolling interests and equity	$ 245,705	$ 212,206

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2022	2021	2020
Revenues:			
Premiums	$ 257,157	$ 226,233	$ 201,478
Products	37,424	34,437	34,145
Services	27,551	24,603	20,016
Investment and other income	2,030	2,324	1,502
Total revenues	324,162	287,597	257,141
Operating costs:			
Medical costs	210,842	186,911	159,396
Operating costs	47,782	42,579	41,704
Cost of products sold	33,703	31,034	30,745
Depreciation and amortization	3,400	3,103	2,891
Total operating costs	295,727	263,627	234,736
Earnings from operations	28,435	23,970	22,405
Interest expense	(2,092)	(1,660)	(1,663)
Earnings before income taxes	26,343	22,310	20,742
Provision for income taxes	(5,704)	(4,578)	(4,973)
Net earnings	20,639	17,732	15,769
Earnings attributable to noncontrolling interests	(519)	(447)	(366)
Net earnings attributable to UnitedHealth Group common shareholders	$ 20,120	$ 17,285	$ 15,403
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$ 21.47	$ 18.33	$ 16.23
Diluted	$ 21.18	$ 18.08	$ 16.03
Basic weighted-average number of common shares outstanding	937	943	949
Dilutive effect of common share equivalents	13	13	12
Diluted weighted-average number of common shares outstanding	950	956	961
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	3	1	8

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2022	2021	2020
Net earnings	$ 20,639	$ 17,732	$ 15,769
Other comprehensive loss:			
Gross unrealized (losses) gains on investment securities during the period	(4,292)	(1,028)	1,058
Income tax effect	984	248	(253)
Total unrealized (losses) gains, net of tax	(3,308)	(780)	805
Gross reclassification adjustment for net realized losses (gains) included in net earnings	139	(173)	(75)
Income tax effect	(32)	40	17
Total reclassification adjustment, net of tax	107	(133)	(58)
Total foreign currency translation gains (losses)	192	(657)	(983)
Other comprehensive loss	(3,009)	(1,570)	(236)
Comprehensive income	17,630	16,162	15,533
Comprehensive income attributable to noncontrolling interests	(519)	(447)	(366)
Comprehensive income attributable to UnitedHealth Group common shareholders	$ 17,111	$ 15,715	$ 15,167

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss): Net Unrealized Gains (Losses) on Investments	Accumulated Other Comprehensive Income (Loss): Foreign Currency Translation (Losses) Gains	Nonredeemable Noncontrolling Interests	Total Equity
Balance at January 1, 2020	948	$ 9	$ 7	$ 61,178	$ 589	$ (4,167)	$ 2,820	$ 60,436
Adjustment to adopt ASU 2016-13				(28)				(28)
Net earnings				15,403			254	15,657
Other comprehensive income (loss)					747	(983)		(236)
Issuances of common stock, and related tax effects	12	1	1,119					1,120
Share-based compensation			647					647
Common share repurchases	(14)	—	(1,576)	(2,674)				(4,250)
Cash dividends paid on common shares ($4.83 per share)				(4,584)				(4,584)
Redeemable noncontrolling interests fair value and other adjustments			(197)					(197)
Acquisition and other adjustments of nonredeemable noncontrolling interests							40	40
Distributions to nonredeemable noncontrolling interests							(277)	(277)
Balance at December 31, 2020	946	10	—	69,295	1,336	(5,150)	2,837	68,328
Net earnings				17,285			360	17,645
Other comprehensive loss					(913)	(657)		(1,570)
Issuances of common stock, and related tax effects	8	—	1,100					1,100
Share-based compensation			729					729
Common share repurchases	(13)	—	(940)	(4,060)				(5,000)
Cash dividends paid on common shares ($5.60 per share)				(5,280)				(5,280)
Redeemable noncontrolling interests fair value and other adjustments			(889)	(106)				(995)
Acquisition and other adjustments of nonredeemable noncontrolling interests							407	407
Distributions to nonredeemable noncontrolling interests							(319)	(319)
Balance at December 31, 2021	941	10	—	77,134	423	(5,807)	3,285	75,045
Net earnings				20,120			406	20,526
Other comprehensive (loss) gains					(3,201)	192		(3,009)
Issuances of common stock, and related tax effects	7	—	903					903
Share-based compensation			875					875
Common share repurchases	(14)	(1)	(1,892)	(5,107)				(7,000)
Cash dividends paid on common shares ($6.40 per share)				(5,991)				(5,991)
Redeemable noncontrolling interests fair value and other adjustments			114					114
Acquisition and other adjustments of nonredeemable noncontrolling interests							374	374
Distributions to nonredeemable noncontrolling interests							(387)	(387)
Balance at December 31, 2022	934	$ 9	$ —	$ 86,156	$ (2,778)	$ (5,615)	$ 3,678	$ 81,450

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2022	2021	2020
Operating activities			
Net earnings	$ 20,639	$ 17,732	$ 15,769
Noncash items:			
Depreciation and amortization	3,400	3,103	2,891
Deferred income taxes	(673)	130	(8)
Share-based compensation	925	800	679
Other, net	(331)	(944)	(52)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(2,523)	(1,000)	(688)
Other assets	(1,374)	(1,031)	(2,195)
Medical costs payable	4,053	2,701	152
Accounts payable and other liabilities	1,964	1,162	5,348
Unearned revenues	126	(310)	278
Cash flows from operating activities	26,206	22,343	22,174
Investing activities			
Purchases of investments	(18,825)	(17,139)	(16,577)
Sales of investments	5,907	7,045	6,489
Maturities of investments	6,081	8,251	7,252
Cash paid for acquisitions, net of cash assumed	(21,458)	(4,821)	(7,139)
Purchases of property, equipment and capitalized software	(2,802)	(2,454)	(2,051)
Cash received from dispositions	3,414	15	221
Other, net	(793)	(1,269)	(727)
Cash flows used for investing activities	(28,476)	(10,372)	(12,532)
Financing activities			
Common share repurchases	(7,000)	(5,000)	(4,250)
Cash dividends paid	(5,991)	(5,280)	(4,584)
Proceeds from common stock issuances	1,253	1,355	1,440
Repayments of long-term debt	(3,015)	(3,150)	(3,150)
Proceeds from (repayments of) short-term borrowings, net	732	(1,302)	872
Proceeds from issuance of long-term debt	14,819	6,933	4,864
Customer funds administered	5,548	622	1,677
Purchases of redeemable noncontrolling interests	(176)	(1,338)	—
Other, net	(1,944)	(295)	(459)
Cash flows from (used for) financing activities	4,226	(7,455)	(3,590)
Effect of exchange rate changes on cash and cash equivalents	34	(62)	(116)
Increase in cash and cash equivalents	1,990	4,454	5,936
Cash and cash equivalents, beginning of period	21,375	16,921	10,985
Cash and cash equivalents, end of period	$ 23,365	$ 21,375	$ 16,921
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,945	$ 1,653	$ 1,704
Cash paid for income taxes	5,222	3,966	4,935

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and "the Company") is a health care and well-being company with a mission to help people live healthier lives and help make the health system work better for everyone. Our two distinct, yet complementary business platforms—Optum and UnitedHealthcare—are working to help build a modern, high-performing health system through improved access, affordability, outcomes and experiences for the individuals and organizations we are privileged to serve.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S.22 Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to estimates and judgments for medical costs payable and goodwill. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premiums

Premium revenues are primarily derived from risk-based arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company's customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios (MLRs) as calculated under the definitions in the Patient Protection and Affordable Care Act (ACA) and related federal and state regulations and implementing regulation, falling below certain targets are required to rebate ratable portions of their premiums annually. Commercial premiums within the Company's individual and small group markets are also subject to the ACA risk adjustment program. Medicare Advantage premium revenue includes the impact of the Centers for Medicare & Medicaid Services (CMS) quality bonuses based on plans' Star rating. Certain of the Company's Medicaid business is also subject to state minimum MLR rebates.

Premium revenues are recognized based on the estimated premiums earned, net of projected rebates, because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues for certain value-based arrangements at its Optum Health care delivery businesses. Under these value-based arrangements, the Company enters into agreements with health plans to stand ready to deliver, integrate, direct and control certain health care services for patients. In exchange, the Company receives a premium that is typically paid on a per-patient per-month basis. The Company considers these value-based arrangements to represent a single performance obligation where premium revenues are recognized in the period in which health care services are made available.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under CMS' risk adjustment payment methodology. CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per

member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis and encounter data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture and submit the necessary and available data to CMS within prescribed deadlines. The Company estimates risk adjustment premium revenues based upon the data submitted and expected to be submitted to CMS. Risk adjustment data for the Company's plans are subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Products and Services

For the Company's Optum Rx pharmacy care services business, the majority of revenues are derived from products sold through a contracted network of retail pharmacies or home delivery, specialty and community health pharmacies. Product revenues include the cost of pharmaceuticals (net of rebates), a negotiated dispensing fee and customer co-payments. Pharmacy products are billed to customers based on the number of transactions occurring during the billing period. Product revenues are recognized when the prescriptions are dispensed. The Company has entered into contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless of whether the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members and accordingly, product revenues are reported on a gross basis.

Services revenue includes a number of services and products sold through Optum. Optum Health's service revenues include net patient service revenues recorded based upon established billing rates, less allowances for contractual adjustments, and are recognized as services are provided. For its financial services offerings, Optum Health charges fees and earns investment income on managed funds. Optum Insight provides software and information products, advisory consulting arrangements and managed services outsourcing contracts, which may be delivered over several years. Optum Insight revenues are generally recognized over time and measured each period based on the progress to date as services are performed or made available to customers.

Services revenue also consists of fees derived from services performed for customers who self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company receives monthly, a fixed fee per employee, which is recognized as revenue as the Company performs, or makes available, the applicable services to the customer. The customers retain the risk of financing health care costs for their employees and employees' dependents, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements. For these fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

As of December 31, 2022 and 2021, accounts receivables related to products and services were $7.1 billion and $5.4 billion, respectively. In 2022 and 2021, the Company had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the Consolidated Balance Sheets as of December 31, 2022 or 2021.

For the years ended December 31, 2022, 2021 and 2020, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price) was not material.

Revenue expected to be recognized in any future year related to remaining performance obligations, excluding revenue pertaining to contracts having an original expected duration of one year or less, contracts where revenue is recognized as invoiced and contracts with variable consideration related to undelivered performance obligations, was $12.5 billion, of which approximately half is expected to be recognized in the next three years.

See Note 14 for disaggregation of revenue by segment and type.

Medical Costs and Medical Costs Payable

The Company's estimate of medical costs payable represents management's best estimate of its liability for unpaid medical costs as of December 31, 2022.

Each period, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months.

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services rendered on behalf of consumers, but for which claims have either not yet been received, processed, or paid. The Company develops estimates for medical care services incurred but not reported (IBNR), which includes estimates for claims which have not been received or fully processed, using an actuarial process consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim processing, seasonal variances in medical care consumption, health care professional contract rate changes, care activity and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography.

In developing its medical costs payable estimates, the Company applies different estimation methods depending on which incurred claims are being estimated. For the most recent two months, the Company estimates claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data are available, supplemented by a review of near-term completion factors (actuarial estimates, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period adjudicated by the Company at the date of estimation). For months prior to the most recent two months, the Company applies the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months.

Cost of Products Sold

The Company's cost of products sold includes the cost of pharmaceuticals dispensed to unaffiliated customers either directly at its home delivery, specialty and community pharmacy locations, or indirectly through its nationwide network of participating pharmacies. Rebates attributable to unaffiliated clients are accrued as rebates receivable and a reduction of cost of products sold, with a corresponding payable for the amounts of the rebates to be remitted to those unaffiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. Cost of products sold also includes the cost of personnel to support the Company's transaction processing services, system sales, maintenance and professional services.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments having an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available. Equity investments, with certain exceptions, are measured at fair value with changes in fair value recognized in net earnings.

The Company excludes unrealized gains and losses on investments in available-for-sale debt securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of equity. To calculate realized gains and losses on the sale of debt securities, the Company specifically identifies the cost of each investment sold.

The Company evaluates an available-for-sale debt security for credit-related impairment by considering the present value of expected cash flows relative to a security's amortized cost, the extent to which fair value is less than amortized cost, the financial condition and near-term prospects of the issuer and specific events or circumstances which may influence the operations of the issuer. Credit-related impairments are recorded as an allowance, with an offset to investment and other income. Non-credit related impairments are recorded through other comprehensive income. If the Company intends to sell an impaired security, or will likely be required to sell a security before recovery of the entire amortized cost, the entire impairment is included in net earnings.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the Company's investment policy.

Assets Under Management

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the AARP Program) and to AARP members and non-members under separate Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP Program include supplemental Medicare benefits, hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

Pursuant to the Company's agreement with AARP, program assets are managed separately from the Company's general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon any transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to the entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts, accrued interest and other miscellaneous amounts due to the Company.

The Company's pharmacy care services businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its affiliated and unaffiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The pharmacy care services businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms and record rebates attributable to affiliated clients as a reduction to medical costs. The Company generally receives rebates two to five months after billing. As of December 31, 2022 and 2021, total pharmaceutical manufacturer rebates receivable included in other receivables in the Consolidated Balance Sheets amounted to $8.2 billion and $7.2 billion, respectively.

As of December 31, 2022 and 2021, the Company's Medicare Part D receivables amounted to $1.3 billion and $3.4 billion, respectively.

Prepaid Expenses and Other Current Assets

Prepaid expenses and other current assets include pharmaceutical drug and supplies inventory of $3.5 billion and $2.9 billion as of December 31, 2022 and 2021, respectively.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 10 years
Buildings	35 to 40 years
Capitalized software	3 to 5 years

Leasehold improvements are depreciated over the shorter of the remaining lease term or their estimated useful economic life.

Operating Leases

The Company leases facilities and equipment under long-term operating leases which are non-cancelable and expire on various dates. At the lease commencement date, lease right-of-use (ROU) assets and lease liabilities are recognized based on the present value of the future minimum lease payments over the lease term, which includes all fixed obligations arising from the lease contract. If an interest rate is not implicit in a lease, the Company utilizes its incremental borrowing rate for a period closely matching the lease term.

The Company's ROU assets are included in other assets, and lease liabilities are included in other current liabilities and other liabilities in the Company's Consolidated Balance Sheet.

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs impairment tests. The Company may first assess qualitative factors to determine if it is more likely than not the carrying value of a reporting unit exceeds its estimated fair value. The Company may also elect to skip the qualitative testing and proceed directly to the quantitative testing. When performing quantitative testing, the Company first estimates the fair values of its reporting units using discounted cash flows. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value and discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test. If the fair value is less than the carrying value of the reporting unit, an impairment is recognized for the difference, up to the carrying amount of goodwill.

There was no impairment of goodwill during the years ended December 31, 2022, 2021 and 2020.

Intangible Assets

The Company's intangible assets are subject to impairment tests when events or circumstances indicate an intangible asset (or asset group) may be impaired. The Company's indefinite-lived intangible assets are also tested for impairment annually. There was no impairment of intangible assets during the years ended December 31, 2022, 2021 and 2020.

Other Current Liabilities

Other current liabilities include health savings account deposits ($13.5 billion and $11.4 billion as of December 31, 2022 and 2021, respectively), accruals for premium rebates payable, the RSF associated with the AARP Program, the current portion of future policy benefits and customer balances.

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short duration customer contracts are primarily charged to expense as incurred.

Redeemable Noncontrolling Interests

Redeemable noncontrolling interests in the Company's subsidiaries whose redemption is outside of the Company's control are classified as temporary equity. These interests primarily relate to put options on unowned shares, which are typically redeemable at fair value after a certain time period. The Company accretes changes in the redemption value to the earliest redemption date utilizing the interest method. If all interests were currently redeemable, the difference between the carrying value and the estimated redemption value is not material. The following table provides details of the Company's redeemable noncontrolling interests' activity for the years ended December 31, 2022 and 2021:

(in millions)	2022	2021
Redeemable noncontrolling interests, beginning of period	$ 1,434	$ 2,211
Net earnings	113	87
Acquisitions	3,108	28
Redemptions	(176)	(1,338)
Distributions	(82)	(255)
Fair value and other adjustments	500	701
Redeemable noncontrolling interests, end of period	$ 4,897	$ 1,434

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably, primarily over four years, and compensation expense related to restricted shares is based on the share price on the date of grant. Stock options vest ratably primarily over four years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options is based on the fair value at the date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP), eligible employees are allowed to purchase the Company's stock at a discounted price, which is 90% of the market price of the Company's common stock at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic earnings per common share attributable to UnitedHealth Group common shareholders by dividing net earnings attributable to UnitedHealth Group common shareholders by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share attributable to UnitedHealth Group common shareholders using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, restricted shares and the ESPP (collectively, common stock equivalents), using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise and the average unrecognized compensation cost. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

3. Investments

A summary of debt securities by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2022				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 4,093	$ 1	$ (285)	$ 3,809
State and municipal obligations	7,702	25	(479)	7,248
Corporate obligations	23,675	17	(1,798)	21,894
U.S. agency mortgage-backed securities	7,379	15	(808)	6,586
Non-U.S. agency mortgage-backed securities	3,077	1	(294)	2,784
Total debt securities — available-for-sale	45,926	59	(3,664)	42,321
Debt securities — held-to-maturity:				
U.S. government and agency obligations	578	—	(14)	564
State and municipal obligations	29	—	(3)	26
Corporate obligations	89	—	—	89
Total debt securities — held-to-maturity	696	—	(17)	679
Total debt securities	$ 46,622	$ 59	$ (3,681)	$ 43,000
December 31, 2021				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,206	$ 23	$ (31)	$ 3,198
State and municipal obligations	6,829	297	(20)	7,106
Corporate obligations	20,947	372	(145)	21,174
U.S. agency mortgage-backed securities	5,868	88	(55)	5,901
Non-U.S. agency mortgage-backed securities	2,819	42	(23)	2,838
Total debt securities — available-for-sale	39,669	822	(274)	40,217
Debt securities — held-to-maturity:				
U.S. government and agency obligations	511	2	(2)	511
State and municipal obligations	30	2	—	32
Corporate obligations	100	—	—	100
Total debt securities — held-to-maturity	641	4	(2)	643
Total debt securities	$ 40,310	$ 826	$ (276)	$ 40,860

Nearly all of the Company's investments in mortgage-backed securities were rated "Triple A" as of December 31, 2022. The Company held $3.7 billion and $3.5 billion of equity securities as of December 31, 2022 and 2021, respectively. The Company's investments in equity securities primarily consist of employee savings plan related investments, venture investments and shares of Brazilian real denominated fixed-income funds with readily determinable fair values. Additionally, the Company's investments included $1.5 billion and $1.3 billion of equity method investments in operating businesses in the health care sector, as of December 31, 2022 and 2021, respectively. The allowance for credit losses on held-to-maturity securities as of December 31, 2022 and 2021 was not material.

The amortized cost and fair value of debt securities as of December 31, 2022, by contractual maturity, were as follows:

	Available-for-Sale		Held-to-Maturity	
(in millions)	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	$ 4,713	$ 4,682	$ 374	$ 369
Due after one year through five years	13,135	12,404	265	256
Due after five years through ten years	12,210	10,897	37	36
Due after ten years	5,412	4,968	20	18
U.S. agency mortgage-backed securities	7,379	6,586	—	—
Non-U.S. agency mortgage-backed securities	3,077	2,784	—	—
Total debt securities	$ 45,926	$ 42,321	$ 696	$ 679

The fair value of available-for-sale debt securities with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

(in millions)	Less Than 12 Months		12 Months or Greater		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2022						
U.S. government and agency obligations	$ 2,007	$ (96)	$ 1,290	$ (189)	$ 3,297	$ (285)
State and municipal obligations	4,630	(288)	1,178	(191)	5,808	(479)
Corporate obligations	13,003	(893)	6,637	(905)	19,640	(1,798)
U.S. agency mortgage-backed securities	3,561	(345)	2,239	(463)	5,800	(808)
Non-U.S. agency mortgage-backed securities	1,698	(128)	976	(166)	2,674	(294)
Total debt securities — available-for-sale	$ 24,899	$ (1,750)	$ 12,320	$ (1,914)	$ 37,219	$ (3,664)
December 31, 2021						
U.S. government and agency obligations	$ 1,976	$ (18)	$ 249	$ (13)	$ 2,225	$ (31)
State and municipal obligations	1,386	(19)	31	(1)	1,417	(20)
Corporate obligations	9,357	(130)	376	(15)	9,733	(145)
U.S. agency mortgage-backed securities	3,078	(52)	116	(3)	3,194	(55)
Non-U.S. agency mortgage-backed securities	1,321	(18)	114	(5)	1,435	(23)
Total debt securities — available-for-sale	$ 17,118	$ (237)	$ 886	$ (37)	$ 18,004	$ (274)

The Company's unrealized losses from all securities as of December 31, 2022 were generated from approximately 35,000 positions out of a total of 41,000 positions. The Company believes it will collect the timely principal and interest due on its debt securities having an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities which impacted the Company's assessment on collectability of principal and interest. At each reporting period, the Company evaluates available-for-sale debt securities for any credit-related impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the expected cash flows, the underlying credit quality and credit ratings of the issuers noting no significant credit deterioration since purchase. As of December 31, 2022, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary. The allowance for credit losses on available-for-sale debt securities as of December 31, 2022 and 2021 was not material.

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input which is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1—Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2—Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);

- Inputs other than quoted prices observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs corroborated by other observable market data.

Level 3—Unobservable inputs cannot be corroborated by observable market data.

There were no transfers in or out of Level 3 financial assets or liabilities during the years ended December 31, 2022 or 2021.

Nonfinancial assets and liabilities or financial assets and liabilities measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. For the years ended December 31, 2022 and 2021, the Company recognized $211 million and $840 million, respectively, of unrealized gains in investment and other income related to fair value adjustments on equity securities primarily in our venture portfolio, based upon transaction of the same or similar security. There were no other significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2022 or 2021.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments which do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt securities and equity securities reported at fair value on a recurring basis are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs currently observable in the markets for similar securities. Inputs often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and nonbinding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment to the prices obtained from the pricing service.

Fair values of debt securities which do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities reported at fair value on a recurring basis are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in corporate bonds, which are not a significant portion of our investments, are estimated using valuation techniques relying heavily on management assumptions and qualitative observations.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on such understanding.

Assets Under Management. Assets under management consists of debt securities and other investments held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Long-Term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2022				
Cash and cash equivalents	$ 23,202	$ 163	$ —	$ 23,365
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,505	304	—	3,809
State and municipal obligations	—	7,248	—	7,248
Corporate obligations	7	21,695	192	21,894
U.S. agency mortgage-backed securities	—	6,586	—	6,586
Non-U.S. agency mortgage-backed securities	—	2,784	—	2,784
Total debt securities — available-for-sale	3,512	38,617	192	42,321
Equity securities	2,043	35	70	2,148
Assets under management	1,788	2,203	96	4,087
Total assets at fair value	$ 30,545	$ 41,018	$ 358	$ 71,921
Percentage of total assets at fair value	42%	57%	1%	100%
December 31, 2021				
Cash and cash equivalents	$ 21,359	$ 16	$ —	$ 21,375
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,017	181	—	3,198
State and municipal obligations	—	7,106	—	7,106
Corporate obligations	40	20,916	218	21,174
U.S. agency mortgage-backed securities	—	5,901	—	5,901
Non-U.S. agency mortgage-backed securities	—	2,838	—	2,838
Total debt securities — available-for-sale	3,057	36,942	218	40,217
Equity securities	2,090	23	64	2,177
Assets under management	1,972	2,376	101	4,449
Total assets at fair value	$ 28,478	$ 39,357	$ 383	$ 68,218
Percentage of total assets at fair value	42%	57%	1%	100%

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2022					
Debt securities — held-to-maturity	$ 577	$ 102	$ —	$ 679	$ 696
Long-term debt and other financing obligations	$ —	$ 53,626	$ —	$ 53,626	$ 56,823
December 31, 2021					
Debt securities — held-to-maturity	$ 534	$ 102	$ 7	$ 643	$ 641
Long-term debt and other financing obligations	$ —	$ 52,583	$ —	$ 52,583	$ 46,003

The carrying amounts reported on the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2022	December 31, 2021
Land and improvements	$ 697	$ 502
Buildings and improvements	5,519	4,882
Computer equipment	2,093	1,851
Furniture and fixtures	2,113	2,014
Less accumulated depreciation	(4,499)	(3,857)
Property and equipment, net	5,923	5,392
Capitalized software	6,636	5,712
Less accumulated amortization	(2,431)	(2,135)
Capitalized software, net	4,205	3,577
Total property, equipment and capitalized software, net	$ 10,128	$ 8,969

Depreciation expense for property and equipment was $1.1 billion for the year ended December 31, 2022, and $1.0 billion for both years ended December 31, 2021 and 2020. Amortization expense for capitalized software for the years ended December 31, 2022, 2021 and 2020 was $1.0 billion, $0.9 billion and $0.8 billion, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	Optum Health	Optum Insight	Optum Rx	Consolidated
Balance at January 1, 2021	$ 27,785	$ 19,844	$ 8,173	$ 15,535	$ 71,337
Acquisitions	60	4,648	96	—	4,804
Foreign currency effects and other adjustments, net	(456)	(268)	350	28	(346)
Balance at December 31, 2021	27,389	24,224	8,619	15,563	75,795
Acquisitions	19	5,158	8,623	3,910	17,710
Foreign currency effects and other adjustments, net	(13)	(144)	2	2	(153)
Balance at December 31, 2022	$ 27,395	$ 29,238	$ 17,244	$ 19,475	$ 93,352

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

(in millions)	December 31, 2022 Gross Carrying Value	December 31, 2022 Accumulated Amortization	December 31, 2022 Net Carrying Value	December 31, 2021 Gross Carrying Value	December 31, 2021 Accumulated Amortization	December 31, 2021 Net Carrying Value
Customer-related	$ 16,303	$ (5,179)	$ 11,124	$ 13,011	$ (4,697)	$ 8,314
Trademarks and technology	2,398	(704)	1,694	1,630	(739)	891
Trademarks and other indefinite-lived	661	—	661	617	—	617
Other	1,176	(254)	922	422	(200)	222
Total	$ 20,538	$ (6,137)	$ 14,401	$ 15,680	$ (5,636)	$ 10,044

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

(in millions, except years)	2022 Fair Value	2022 Weighted-Average Useful Life	2021 Fair Value	2021 Weighted-Average Useful Life
Customer-related	$ 3,927	15 years	$ 484	9 years
Trademarks and technology	1,058	6 years	147	5 years
Other	776	13 years	29	11 years
Total acquired finite-lived intangible assets	$ 5,761	13 years	$ 660	8 years

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2023	$ 1,562
2024	1,478
2025	1,360
2026	1,206
2027	1,154

Amortization expense relating to intangible assets for the years ended December 31, 2022, 2021 and 2020 was $1.3 billion, $1.2 billion and $1.1 billion, respectively.

7. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2022	2021	2020
Medical costs payable, beginning of period	$ 24,483	$ 21,872	$ 21,690
Acquisitions	308	88	316
Reported medical costs:			
Current year	211,252	188,631	160,276
Prior years	(410)	(1,720)	(880)
Total reported medical costs	210,842	186,911	159,396
Medical payments:			
Payments for current year	(184,049)	(165,524)	(139,974)
Payments for prior years	(22,528)	(18,864)	(19,556)
Total medical payments	(206,577)	(184,388)	(159,530)
Medical costs payable, end of period	$ 29,056	$ 24,483	$ 21,872

For the year ended December 31, 2022, prior year's medical cost reserve development included no individual factors that were significant. For the years ended December 31, 2021 and 2020, prior years' medical cost reserve development was primarily driven by lower than expected care activity. Additionally, prior years' medical cost reserve development in the year ended December 31, 2021 was driven by care patterns disrupted by COVID-19.

Medical costs payable included IBNR of $20.0 billion and $17.1 billion at December 31, 2022 and 2021, respectively. Substantially all of the IBNR balance as of December 31, 2022 relates to the current year.

The following is information about incurred and paid medical cost development as of December 31, 2022:

(in millions) Year	Net Incurred Medical Costs For the Years Ended December 31, 2021	2022
2021	$ 188,631	$ 188,407
2022		211,252
Total		$ 399,659

(in millions) Year	Net Cumulative Medical Payments For the Years Ended December 31, 2021	2022
2021	$ (165,524)	$ (186,944)
2022		(184,049)
Total		(370,993)
Net remaining outstanding liabilities prior to 2021		390
Total medical costs payable		$ 29,056

8. Short-Term Borrowings and Long-Term Debt

Short-term borrowings and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	Carrying Value As of December 31, 2022	2021
Commercial paper	$ 800	$ —
$1,100 million 2.875% notes due March 2022	—	1,097
$1,000 million 3.350% notes due July 2022	—	999
$900 million 2.375% notes due October 2022	—	899
$15 million 0.000% notes due November 2022	—	14
$625 million 2.750% notes due February 2023	622	632
$750 million 2.875% notes due March 2023	746	768
$750 million 3.500% notes due June 2023	750	749
$750 million 3.500% notes due February 2024	749	748
$1,000 million 0.550% notes due May 2024	998	996
$750 million 2.375% notes due August 2024	749	748
$500 million 5.000% notes due October 2024	499	—
$2,000 million 3.750% notes due July 2025	1,995	1,994
$750 million 5.150% notes due October 2025	747	—
$300 million 3.700% notes due December 2025	299	299
$500 million 1.250% notes due January 2026	498	497
$1,000 million 3.100% notes due March 2026	998	997
$1,000 million 1.150% notes due May 2026	893	972
$750 million 3.450% notes due January 2027	748	747
$625 million 3.375% notes due April 2027	622	621
$600 million 3.700% notes due May 2027	597	—
$950 million 2.950% notes due October 2027	943	942
$1,000 million 5.250% notes due February 2028	1,008	—
$1,150 million 3.850% notes due June 2028	1,145	1,144
$850 million 3.875% notes due December 2028	845	844
$900 million 4.000% notes due May 2029	849	—
$1,000 million 2.875% notes due August 2029	886	1,023
$1,250 million 5.300% notes due February 2030	1,269	—
$1,250 million 2.000% notes due May 2030	1,237	1,235
$1,500 million 2.300% notes due May 2031	1,256	1,482
$1,500 million 4.200% notes due May 2032	1,393	—
$2,000 million 5.350% notes due February 2033	2,037	—
$1,000 million 4.625% notes due July 2035	993	993
$850 million 5.800% notes due March 2036	840	839
$500 million 6.500% notes due June 2037	493	492
$650 million 6.625% notes due November 2037	642	642
$1,100 million 6.875% notes due February 2038	1,079	1,078
$1,250 million 3.500% notes due August 2039	1,242	1,242
$1,000 million 2.750% notes due May 2040	967	966
$300 million 5.700% notes due October 2040	296	296
$350 million 5.950% notes due February 2041	346	346
$1,500 million 3.050% notes due May 2041	1,483	1,483
$600 million 4.625% notes due November 2041	590	589
$502 million 4.375% notes due March 2042	486	485
$625 million 3.950% notes due October 2042	609	608
$750 million 4.250% notes due March 2043	736	736
$2,000 million 4.750% notes due July 2045	1,975	1,974
$750 million 4.200% notes due January 2047	739	739
$725 million 4.250% notes due April 2047	718	718
$950 million 3.750% notes due October 2047	935	934

(in millions, except percentages)	Carrying Value As of December 31, 2022	2021
$1,350 million 4.250% notes due June 2048	1,331	1,330
$1,100 million 4.450% notes due December 2048	1,087	1,087
$1,250 million 3.700% notes due August 2049	1,236	1,236
$1,250 million 2.900% notes due May 2050	1,210	1,209
$2,000 million 3.250% notes due May 2051	1,971	1,970
$2,000 million 4.750% notes due May 2052	1,965	—
$2,000 million 5.875% notes due February 2053	1,968	—
$1,250 million 3.875% notes due August 2059	1,228	1,228
$1,000 million 3.125% notes due May 2060	966	965
$1,000 million 4.950% notes due May 2062	981	—
$1,500 million 6.050% notes due February 2063	1,466	—
Total short-term borrowings and long-term debt	$ 56,756	$ 44,632

The Company's long-term debt obligations also included $0.9 billion and $1.4 billion of other financing obligations, of which $192 million and $611 million were current as of December 31, 2022 and 2021, respectively.

Maturities of short-term borrowings and long-term debt for the years ending December 31 are as follows:

(in millions)	
2023	$ 3,117
2024	3,136
2025	3,186
2026	2,636
2027	3,061
Thereafter	43,638

Short-Term Borrowings

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers.

The Company has $6.0 billion five-year, $6.0 billion three-year and $6.0 billion 364-day revolving bank credit facilities with 25 banks, which mature in December 2027, December 2025 and December 2023, respectively. These facilities provide full liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of December 31, 2022, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on one-month term Secured Overnight Financing Rate (SOFR) plus a SOFR Adjustment of 10 basis points plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of December 31, 2022, annual interest rates would have ranged from 5.1% to 7.5%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including requiring the Company to maintain a debt to debt-plus-shareholders' equity ratio of not more than 60%. The Company was in compliance with its debt covenants as of December 31, 2022.

9. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change

in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2022	2021	2020
Current Provision:			
Federal	$ 4,842	$ 3,451	$ 4,098
State and local	855	481	392
Foreign	680	516	491
Total current provision	6,377	4,448	4,981
Deferred (benefit) provision	(673)	130	(8)
Total provision for income taxes	$ 5,704	$ 4,578	$ 4,973

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	2022		2021		2020	
Tax provision at the U.S. federal statutory rate	$ 5,532	21.0%	$ 4,685	21.0%	$ 4,356	21.0%
State income taxes, net of federal benefit	621	2.4	419	1.9	315	1.5
Share-based awards — excess tax benefit	(110)	(0.4)	(100)	(0.4)	(130)	(0.6)
Non-deductible compensation	150	0.6	144	0.6	134	0.7
Health insurance tax	—	—	—	—	626	3.0
Foreign rate differential	(265)	(1.0)	(246)	(1.1)	(164)	(0.8)
Other, net	(224)	(0.9)	(324)	(1.5)	(164)	(0.8)
Provision for income taxes	$ 5,704	21.7%	$ 4,578	20.5%	$ 4,973	24.0%

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2022	2021
Deferred income tax assets:		
Accrued expenses and allowances	$ 707	$ 723
U.S. federal and state net operating loss carryforwards	540	287
Share-based compensation	154	117
Nondeductible liabilities	341	296
Non-U.S. tax loss carryforwards	631	435
Lease liability	972	1,284
Net unrealized losses on investments	829	—
Other-domestic	291	228
Other-non-U.S.	423	376
Subtotal	4,888	3,746
Less: valuation allowances	(291)	(198)
Total deferred income tax assets	4,597	3,548
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(3,520)	(2,658)
Non-U.S. goodwill and intangible assets	(550)	(512)
Capitalized software	(548)	(833)
Depreciation and amortization	(520)	(349)
Prepaid expenses	(275)	(256)
Outside basis in partnerships	(653)	(565)
Lease right-of-use asset	(958)	(1,267)
Net unrealized gains on investments	—	(125)
Other-non-U.S.	(342)	(248)
Total deferred income tax liabilities	(7,366)	(6,813)
Net deferred income tax liabilities	$ (2,769)	$ (3,265)

Valuation allowances are provided when it is considered more likely than not deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Gross federal net operating loss carryforwards of $490 million expire beginning in 2023 through 2037 and $611 million have an indefinite carryforward period; state net operating loss carryforwards expire beginning in 2023 through 2042, with some having an indefinite carryforward period. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2022, the Company's undistributed earnings from non-U.S. subsidiaries are intended to be indefinitely reinvested in non-U.S. operations, and therefore no U.S. deferred taxes have been recorded. Taxes payable on the remittance of such earnings would be minimal.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2022	2021	2020
Gross unrecognized tax benefits, beginning of period	$ 2,310	$ 1,829	$ 1,423
Gross increases:			
Current year tax positions	586	538	416
Prior year tax positions	206	10	120
Gross decreases:			
Prior year tax positions	(21)	(47)	(130)
Statute of limitations lapses	—	(20)	—
Gross unrecognized tax benefits, end of period	$ 3,081	$ 2,310	$ 1,829

The Company believes it is reasonably possible its liability for unrecognized tax benefits will decrease in the next twelve months by $260 million as a result of audit settlements and the expiration of statutes of limitations.

The Company classifies net interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Statements of Operations. During the years ended December 31, 2022, 2021 and 2020, the Company recognized $64 million, $66 million and $52 million of net interest and penalties, respectively. The Company had $253 million and $194 million of accrued interest and penalties for uncertain tax positions as of December 31, 2022 and 2021, respectively. These amounts are not included in the reconciliation above. As of December 31, 2022, there were $1.7 billion of unrecognized tax benefits which, if recognized, would affect the effective tax rate.

The Company currently files income tax returns in the United States, various states and localities and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2016 and prior. The Company's 2017 through 2020 tax years are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to the 2014 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2015 and forward.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated insurance and HMO subsidiaries are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions which may be paid to their parent companies. In the United States, most of these state regulations and standards are generally consistent with model regulations established by the NAIC. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory

limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

For the year ended December 31, 2022, the Company's domestic insurance and HMO subsidiaries paid their parent companies dividends of $8.8 billion, including $7.4 billion of extraordinary dividends. For the year ended December 31, 2021, the Company's domestic insurance and HMO subsidiaries paid their parent companies dividends of $8.0 billion, including $4.7 billion of extraordinary dividends.

The Company's global financially regulated subsidiaries had estimated aggregate statutory capital and surplus of $33.8 billion as of December 31, 2022. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's global financially regulated subsidiaries was approximately $15.4 billion as of December 31, 2022.

Optum Bank must meet minimum capital requirements of the FDIC under the capital adequacy rules to which it is subject. At December 31, 2022, the Company believes Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain restrictions. In June 2018, the Board of Directors renewed the Company's share repurchase program with an authorization to repurchase up to 100 million shares of its common stock.

A summary of common share repurchases for the years ended December 31, 2022 and 2021 is as follows:

	Years Ended December 31,	
(in millions, except per share data)	**2022**	**2021**
Common share repurchases, shares	14	13
Common share repurchases, average price per share	$ 501.67	$ 389.92
Common share repurchases, aggregate cost	$ 7,000	$ 5,000
Board authorized shares remaining	31	45

Dividends

In June 2022, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of $6.60 compared to $5.80 per share, which the Company had paid since June 2021. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of the Company's 2022 dividend payments:

Payment Date	**Amount per Share**	**Total Amount Paid**
		(in millions)
March 22	$ 1.45	$ 1,363
June 28	1.65	1,545
September 20	1.65	1,542
December 13	1.65	1,541

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options and restricted shares. As of December 31, 2022, the Company had 59 million shares available for future grants of share-based awards under the 2020 Stock Incentive Plan. As of December 31, 2022, there were 18 million shares of common stock available for issuance under the ESPP.

Stock Options

Stock option activity for the year ended December 31, 2022 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	25	$ 241		
Granted	4	459		
Exercised	(5)	215		
Forfeited	(1)	356		
Outstanding at end of period	23	281	5.8	$ 5,914
Exercisable at end of period	13	213	4.4	4,170
Vested and expected to vest, end of period	23	278	5.7	5,854

Restricted Shares

Restricted share activity for the year ended December 31, 2022 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	4	$ 303
Granted	2	483
Vested	(2)	287
Nonvested at end of period	4	401

Other Share-Based Compensation Data

	For the Years Ended December 31,		
(in millions, except per share amounts)	2022	2021	2020
Stock Options			
Weighted-average grant date fair value of shares granted, per share	$ 116	$ 71	$ 54
Total intrinsic value of stock options exercised	1,419	1,519	1,736
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	483	352	303
Total fair value of restricted shares vested	$ 760	$ 560	$ 574
Employee Stock Purchase Plan			
Number of shares purchased	1	1	1
Share-Based Compensation Items			
Share-based compensation expense, before tax	$ 925	$ 800	$ 679
Share-based compensation expense, net of tax effects	836	719	619
Income tax benefit realized from share-based award exercises	207	173	208

(in millions, except years)	December 31, 2022
Unrecognized compensation expense related to share awards	$ 1,165
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options were as follows:

	For the Years Ended December 31,		
	2022	2021	2020
Risk-free interest rate	1.9% - 4.3%	0.7% - 1.2%	0.2% - 1.4%
Expected volatility	30.6% - 30.8%	29.2% - 29.8%	22.2% - 29.5%
Expected dividend yield	1.2%	1.3% - 1.5%	1.4% - 1.7%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	4.7	4.8	5.1

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option exercises and forfeitures within the valuation model. The expected lives of options granted represents the period of time the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2022, 2021 and 2020.

In addition, the Company maintains non-qualified, deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus. The deferrals are recorded within long-term investments with an approximately equal amount in other liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $1.6 billion and $1.8 billion as of December 31, 2022 and 2021, respectively.

12. Commitments and Contingencies

Leases

Operating lease costs, including immaterial variable and short-term lease costs, were $1.3 billion, $1.2 billion and $1.1 billion for the years ended December 31, 2022, 2021 and 2020, respectively. Cash payments made on the Company's operating lease liabilities were $996 million, $921 million and $865 million for the years ended December 31, 2022, 2021 and 2020, respectively, which were classified within operating activities in the Consolidated Statements of Cash Flows. As of December 31, 2022, the Company's weighted-average remaining lease term and weighted-average discount rate for its operating leases were 8.6 years and 3.4%, respectively.

As of December 31, 2022, future minimum annual lease payments under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2023	$ 997
2024	858
2025	702
2026	578
2027	475
Thereafter	2,028
Total future minimum lease payments	5,638
Less imputed interest	(808)
Total	$ 4,830

Other Commitments

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2022, 2021 or 2020.

Pending Acquisitions

As of December 31, 2022, the Company has entered into agreements to acquire companies in the health care sector, most notably, LHC Group, Inc. (NASDAQ: LHCG), subject to regulatory approval and other customary closing conditions. The total anticipated capital required for these acquisitions, excluding the payoff of acquired indebtedness, is approximately $9 billion. The Company completed the acquisition of LHC Group, Inc. on February 22, 2023.

Legal Matters

The Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable a loss may be incurred.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice (DOJ), the SEC, the IRS, the U.S. Drug Enforcement Administration, the U.S. Department of Labor, the FDIC, Consumer Financial Protection Bureau, the Defense Contract Audit Agency and other governmental authorities. Similarly, our international businesses are also subject to investigations, audits and reviews by applicable foreign governments, including South American and other non-U.S. governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans.

On February 14, 2017, the DOJ announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, the DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome which may result from this matter given its procedural status.

13. Business Combinations

On October 3, 2022, the Company acquired all of the outstanding common shares of Change Healthcare Inc. (Change) and funded Change's payoff of its outstanding debt and credit facility for a total of $13.9 billion in cash. The combination of the Company and Change will connect and simplify the core clinical, administrative and payment processes health care providers and payers depend on to serve patients. Change brings key technologies, connections and advanced clinical decision, administrative and financial support capabilities, enabling better workflow and transactional connectivity across the health care system.

Subsequent to closing and as planned, the Company sold Change's claims editing business to an affiliate of investment funds of TPG Inc. for $2.2 billion in cash. The net assets and net liabilities associated with this sale were classified as held-for-sale at the time of acquisition. There was no gain or loss associated with this transaction.

During the year ended December 31, 2022, the Company completed several other business combinations for total consideration of $8.8 billion. The Company also sold other businesses for $1.2 billion of cash, with a carrying value of $600 million, and the difference reflected in the Consolidated Statement of Operations.

Acquired assets (liabilities) at acquisition date were:

(in millions)	Change	Other Acquisitions	Total
Cash and cash equivalents	$ 222	$ 523	$ 745
Accounts receivable and other current assets	925	696	1,621
Assets held-for-sale	2,310	—	2,310
Property, equipment and other long-term assets	254	1,882	2,136
Other intangible assets	4,050	1,764	5,814
Total identifiable assets acquired	7,761	4,865	12,626
Medical costs payable	—	(308)	(308)
Accounts payable and other current liabilities	(1,017)	(843)	(1,860)
Liabilities held-for-sale	(101)	—	(101)
Other long-term liabilities	(1,193)	(713)	(1,906)
Total identifiable liabilities acquired	(2,311)	(1,864)	(4,175)
Total net identifiable assets	5,450	3,001	8,451
Goodwill	8,496	9,214	17,710
Redeemable noncontrolling interests	—	(3,108)	(3,108)
Nonredeemable noncontrolling interests	—	(370)	(370)
Net assets acquired	$ 13,946	$ 8,737	$ 22,683

The majority of goodwill is not deductible for income tax purposes. The preliminary purchase price allocations for the various business combinations are subject to adjustment as valuation analyses, primarily related to intangible assets and contingent liabilities, are finalized.

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired consisted of the following:

	Change		Other Acquisitions		Total	
(in millions, except years)	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life
Customer-related	$ 3,063	15 years	$ 864	13 years	$ 3,927	15 years
Trademarks and technology	977	6 years	81	4 years	1,058	6 years
Other	10	1 year	766	13 years	776	13 years
Total acquired finite-lived intangible assets	$ 4,050	13 years	$ 1,711	13 years	$ 5,761	13 years

The results of operations and financial condition of acquired entities have been included in the Company's consolidated results and the results of the corresponding operating segment as of the date of acquisition. Through December 31, 2022, acquired entities impact on revenues and net earnings was not material.

Unaudited pro forma revenues and net earnings for the years ended December 31, 2022 and 2021, as if the business combinations had occurred on January 1, 2021, were immaterial for both periods.

14. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics, products and services, customers, distribution methods and operational processes which operate in a similar regulatory environment are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State. The U.S. businesses share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology and consumer engagement infrastructure and other resources. Domestically, UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for employers and individuals. Globally, UnitedHealthcare Employer & Individual provides health and dental benefits and hospital and clinical services to employers and individuals in South America and other diversified global businesses. UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs. UnitedHealthcare Community & State provides diversified health care benefits products and services to state programs caring for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage.
- *Optum Health* focuses on care delivery, care management, wellness and consumer engagement, and health financial services. Optum Health is building a comprehensive, connected health care delivery and engagement platform by directly providing high-quality care, helping people manage chronic and complex health needs, and proactively engaging consumers in managing their health through in-person, in-home, virtual and digital clinical platforms.
- *Optum Insight* brings together advanced analytics, technology and health care expertise to deliver integrated services and solutions. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations depend on Optum Insight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.
- *Optum Rx* offers pharmacy care services and programs, including retail network contracting, home delivery, specialty and community health pharmacy services, purchasing and clinical capabilities, and develops programs in areas such as step therapy, formulary management, drug adherence and disease/drug therapy management. Optum Rx integrates pharmacy and medical care and is positioned to serve patients with complex clinical needs and consumers looking for a better digital pharmacy experience with transparent pricing.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy care products and services to UnitedHealthcare customers by Optum Rx; care delivery, care management services and certain product offerings sold to UnitedHealthcare by Optum Health; and health information and technology solutions, consulting and other services sold to UnitedHealthcare by Optum Insight. These transactions are recorded at management's estimate of fair value. Transactions with affiliated customers are eliminated in consolidation. Assets and liabilities jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned so each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 38%, 36% and 36% for 2022, 2021 and 2020, respectively, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 97% of consolidated total revenues for 2022, 2021 and 2020. Long-lived fixed assets located in the United States represented approximately 81% and 78% of the total long-lived fixed assets as of December 31, 2022 and 2021, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Employer & Individual's international businesses.

The following table presents the reportable segment financial information:

(in millions)	UnitedHealthcare	Optum					Corporate and Eliminations	Consolidated
		Optum Health	Optum Insight	Optum Rx	Optum Eliminations	Optum		
2022								
Revenues — unaffiliated customers:								
Premiums	$ 238,783	$ 18,374	$ —	$ —	$ —	$ 18,374	$ —	$ 257,157
Products	—	72	180	37,172	—	37,424	—	37,424
Services	10,035	10,917	4,996	1,603	—	17,516	—	27,551
Total revenues — unaffiliated customers	248,818	29,363	5,176	38,775	—	73,314	—	322,132
Total revenues — affiliated customers	—	40,883	9,288	60,936	(2,760)	108,347	(108,347)	—
Investment and other income	923	928	117	62	—	1,107	—	2,030
Total revenues	$ 249,741	$ 71,174	$ 14,581	$ 99,773	$ (2,760)	$182,768	$ (108,347)	$ 324,162
Earnings from operations	$ 14,379	$ 6,032	$ 3,588	$ 4,436	$ —	$ 14,056	$ —	$ 28,435
Interest expense	—	—	—	—	—	—	(2,092)	(2,092)
Earnings before income taxes	$ 14,379	$ 6,032	$ 3,588	$ 4,436	$ —	$ 14,056	$ (2,092)	$ 26,343
Total assets	$ 107,094	$ 68,950	$ 31,090	$ 47,476	$ —	$147,516	$ (8,905)	$ 245,705
Purchases of property, equipment and capitalized software	799	997	698	308	—	2,003	—	2,802
Depreciation and amortization	973	943	841	643	—	2,427	—	3,400
2021								
Revenues — unaffiliated customers:								
Premiums	$ 212,381	$ 13,852	$ —	$ —	$ —	$ 13,852	$ —	$ 226,233
Products	—	32	159	34,246	—	34,437	—	34,437
Services	9,661	9,894	3,936	1,112	—	14,942	—	24,603
Total revenues — unaffiliated customers	222,042	23,778	4,095	35,358	—	63,231	—	285,273
Total revenues — affiliated customers	—	29,234	7,867	55,779	(2,013)	90,867	(90,867)	—
Investment and other income	857	1,053	237	177	—	1,467	—	2,324
Total revenues	$ 222,899	$ 54,065	$ 12,199	$ 91,314	$ (2,013)	$155,565	$ (90,867)	$ 287,597
Earnings from operations	$ 11,975	$ 4,462	$ 3,398	$ 4,135	$ —	$ 11,995	$ —	$ 23,970
Interest expense	—	—	—	—	—	—	(1,660)	(1,660)
Earnings before income taxes	$ 11,975	$ 4,462	$ 3,398	$ 4,135	$ —	$ 11,995	$ (1,660)	$ 22,310
Total assets	$ 102,967	$ 60,474	$ 16,868	$ 40,181	$ —	$117,523	$ (8,284)	$ 212,206
Purchases of property, equipment and capitalized software	795	791	567	301	—	1,659	—	2,454
Depreciation and amortization	1,004	818	684	597	—	2,099	—	3,103
2020								
Revenues — unaffiliated customers:								
Premiums	$ 191,679	$ 9,799	$ —	$ —	$ —	$ 9,799	$ —	$ 201,478
Products	—	33	135	33,977	—	34,145	—	34,145
Services	8,464	6,815	3,687	1,050	—	11,552	—	20,016
Total revenues — unaffiliated customers	200,143	16,647	3,822	35,027	—	55,496	—	255,639
Total revenues — affiliated customers	—	22,481	6,941	52,420	(1,800)	80,042	(80,042)	—
Investment and other income	732	680	39	51	—	770	—	1,502
Total revenues	$ 200,875	$ 39,808	$ 10,802	$ 87,498	$ (1,800)	$136,308	$ (80,042)	$ 257,141
Earnings from operations	$ 12,359	$ 3,434	$ 2,725	$ 3,887	$ —	$ 10,046	$ —	$ 22,405
Interest expense	—	—	—	—	—	—	(1,663)	(1,663)
Earnings before income taxes	$ 12,359	$ 3,434	$ 2,725	$ 3,887	$ —	$ 10,046	$ (1,663)	$ 20,742
Total assets	$ 98,229	$ 52,073	$ 15,425	$ 39,280	$ —	$106,778	$ (7,718)	$ 197,289
Purchases of property, equipment and capitalized software	687	715	461	188	—	1,364	—	2,051
Depreciation and amortization	920	703	670	598	—	1,971	—	2,891

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) designed to provide reasonable assurance the information required to be disclosed by us in reports we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2022. Based upon their evaluation, our Chief Executive Officer and Chief Financial Officer concluded our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2022.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2022 which have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control Over Financial Reporting as of December 31, 2022

Management of UnitedHealth Group Incorporated and Subsidiaries (the Company) is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2022. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in Internal Control-Integrated Framework (2013). Based on our assessment and the COSO criteria, we believe that, as of December 31, 2022, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2022, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2022, based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2022, based on criteria established in Internal Control—Integrated Framework (2013) issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2022, of the Company and our report dated February 24, 2023, expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2022. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 24, 2023

ITEM 9B. OTHER INFORMATION

None.

ITEM 9C. DISCLOSURE REGARDING FOREIGN JURISDICTIONS THAT PREVENT INSPECTIONS

Not Applicable.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

DIRECTORS OF THE REGISTRANT

The following sets forth certain information regarding our directors as of February 24, 2023, including their name and principal occupation or employment:

Timothy Flynn
Retired Chair
KPMG International

Paul Garcia
Retired Chair and Chief Executive Officer
Global Payments Inc.

Kristen Gil
Vice President and Business Finance Officer
Alphabet Inc

Stephen Hemsley
Chair
UnitedHealth Group

Michele Hooper
Lead Independent Director
UnitedHealth Group
President and Chief Executive Officer
The Directors' Council

F. William McNabb III
Former Chairman and Chief Executive Officer
The Vanguard Group, Inc.

Valerie Montgomery Rice, M.D.
President and Chief Executive Officer
Morehouse School of Medicine

John Noseworthy, M.D.
Former Chief Executive Officer and President
Mayo Clinic

Andrew Witty
Chief Executive Officer
UnitedHealth Group

Pursuant to General Instruction G(3) to Form 10-K and the Instruction to Item 401 of Regulation S-K, information regarding our executive officers is provided in Part I, Item 1 under the caption "Information About our Executive Officers."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller and persons performing similar functions. The code of ethics, entitled Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at www.unitedhealthgroup.com. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business." We intend to satisfy the SEC's disclosure requirements regarding amendments to, or waivers of, the code of ethics for our senior financial officers by posting such information on our website indicated above.

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance" and "Proposal 1-Election of Directors" in our definitive proxy statement for our 2023 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402 and 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance—Risk Oversight" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2023 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information as of December 31, 2022, concerning shares of common stock authorized for issuance under all of our equity compensation plans:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(in millions)		(in millions)
Equity compensation plans approved by shareholders [1]	23	$ 279	77[3]
Equity compensation plans not approved by shareholders [2]	—		—
Total [2]	23	$ 279	77

(1) Consists of the UnitedHealth Group Incorporated 2020 Stock Incentive Plan, as amended, and the UnitedHealth Group 1993 Employee Stock Purchase Plan, as amended.

(2) Excludes 459,000 shares underlying stock options assumed by us in connection with acquisitions. These options have a weighted-average exercise price of $358 and an average remaining term of approximately 4 years. These options are administered pursuant to the terms of the plans under which the options originally were granted. No future awards will be granted under these acquired plans.

(3) Includes 18 million shares of common stock available for future issuance under the 1993 Employee Stock Purchase Plan as of December 31, 2022, and 59 million shares available under the 2020 Stock Incentive Plan as of December 31, 2022. Shares available under the 2020 Stock Incentive Plan may become the subject of future awards in the form of stock options, stock appreciation rights, restricted stock, restricted stock units, performance awards and other stock-based awards.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2023 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2023 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Disclosure of Fees Paid to Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2023 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBIT AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2022 and 2021.
- Consolidated Statements of Operations for the years ended December 31, 2022, 2021, and 2020.
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2022, 2021, and 2020.
- Consolidated Statements of Changes in Equity for the years ended December 31, 2022, 2021, and 2020.
- Consolidated Statements of Cash Flows for the years ended December 31, 2022, 2021, and 2020.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

- Schedule I—Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

(b) The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

EXHIBIT INDEX**

3.1	Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A, Commission File No. 1-10864, filed on July 1, 2015)
3.2	Amended and Restated Bylaws of UnitedHealth Group Incorporated, effective February 23, 2021 (incorporated by reference to Exhibit 3.2 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on February 26, 2021)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated as of November 15, 1988, amended as of November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)

4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
4.5	Description of Common Stock (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.1	UnitedHealth Group 2020 Stock Incentive Plan (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8, SEC File Number 333-238854, filed on June 1, 2020)
*10.2	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (2023 Version)
*10.3	Form of Agreement for Nonqualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (2023 Version)
*10.4	Form of Agreement for Performance-Based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (2023 Version)
*10.5	Form of Agreement for Restricted Stock Unit Award under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (Witty) (2023 Version)
*10.6	Form of Agreement for Nonqualified Stock Option Award under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (Witty) (2023 Version)
*10.7	Form of Agreement for Performance-Based Restricted Stock Unit Award under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (Witty) (2023 Version)
*10.8	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2021)
*10.9	Form of Agreement for Nonqualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2021)
*10.10	Form of Agreement for Performance-Based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2021)
*10.11	Form of Agreement for Restricted Stock Unit Award under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (Witty) (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2021)
*10.12	Form of Agreement for Nonqualified Stock Option Award under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (Witty) (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2021)
*10.13	Form of Agreement for Performance-Based Restricted Stock Unit Award under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (Witty) (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2021)
*10.14	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and restated in 2018 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2018)
*10.15	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)

*10.16	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.17	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.18	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.19	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2021)
*10.20	Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on July 1, 2015)
*10.21	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.22	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.23	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.24	Second Amendment, dated as of November 5, 2015, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.25	UnitedHealth Group Executive Savings Plan (2021 Statement) (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2020)
*10.26	First Amendment of UnitedHealth Group Executive Savings Plan (2021 Statement)
*10.27	Second Amendment of UnitedHealth Group Executive Savings Plan (2021 Statement)
*10.28	Executive Long-Term Disability Program, dated as of January 1, 2021
*10.29	Summary of Non-Management Director Compensation, effective as of October 1, 2022
*10.30	UnitedHealth Group Directors' Compensation Deferral Plan (2023 Statement)
*10.31	Avery Parent Holdings, Inc. 2020 Stock Option and Grant Plan
*10.32	Change Healthcare Inc. 2019 Omnibus Incentive Plan (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-267716, filed on October 3, 2022)
*10.33	Amended and Restated HCIT Holdings, Inc. 2009 Equity Incentive Plan (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-267716, filed on October 3, 2022)
*10.34	Audax Health Solutions, Inc. 2010 Equity Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 to Registration Statement on Form S-8, SEC File Number 333-205826, filed on February 15, 2017)

*10.35	Surgical Care Affiliates, Inc. 2016 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.36	Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.37	Surgical Care Affiliates, Inc. Management Equity Incentive Plan (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.38	Surgical Care Affiliates, Inc. Directors and Consultants Equity Incentive Plan (incorporated by reference to Exhibit 4.6 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.39	The Advisory Board Company Amended and Restated 2009 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on June 15, 2015)
*10.40	The Advisory Board Company 2005 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on November 17, 2005)
*10.41	Amended and Restated Employment Agreement, effective as of June 7, 2016, between United HealthCare Services, Inc. and John Rex (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
*10.42	Amended and Restated Employment Agreement, dated February 3, 2021, between the Company and Andrew P Witty (incorporated by reference to Exhibit 5.02 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on February 8, 2021)
*10.43	Amended and Restated Employment Agreement, effective as of March 16, 2015, between United HealthCare Services, Inc. and Dirk McMahon (incorporated by reference to Exhibit 10.44 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.44	Amendment to Employment Agreement, effective as of May 31, 2017, between United HealthCare Services, Inc. and Dirk McMahon (incorporated by reference to Exhibit 10.45 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.45	Amendment to Employment Agreement, effective as of March 12, 2019, between United HealthCare Services, Inc. and Dirk McMahon (incorporated by reference to Exhibit 10.46 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.46	Amended and Restated Employment Agreement, effective as of February 12, 2018, between United HealthCare Services, Inc. and Brian R. Thompson (incorporated by reference to Exhibit 10.38 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2021)
*10.47	Employment Agreement, effective as of February 28, 2022, between United HealthCare Services, Inc. and Rupert M. Bondy
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data")
21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS	XBRL Instance Document - the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document.
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document.
104	Cover Page Interactive Data File (formatted as Inline XBRL and embedded within Exhibit 101).

* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

Schedule I—Condensed Financial Information of Registrant (Parent Company Only).

Schedule I

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statement Schedule

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2022 and 2021, and for each of the three years in the period ended December 31, 2022, and the Company's internal control over financial reporting as of December 31, 2022, and have issued our reports thereon dated February 24, 2023; such reports are included elsewhere in this Form 10-K. Our audits also included the financial statement schedule of the Company listed in the Index at Item 15. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statement schedule based on our audits. In our opinion, the financial statement schedule, when considered in relation to the consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 24, 2023

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2022	December 31, 2021
Assets		
Current assets:		
Cash and cash equivalents	$ 266	$ 2,167
Other current assets	753	503
Total current assets	1,019	2,670
Equity in net assets of subsidiaries	136,562	116,907
Long-term notes receivable from subsidiaries	6,201	5,680
Other assets	504	32
Total assets	$ 144,286	$ 125,289
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 835	$ 605
Current portion of notes payable to subsidiaries	8,699	8,105
Short-term borrowings and current maturities of long-term debt	2,918	3,009
Total current liabilities	12,452	11,719
Long-term debt, less current maturities	53,838	41,623
Other liabilities	224	187
Total liabilities	66,514	53,529
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 934 and 941 issued and outstanding	9	10
Retained earnings	86,156	77,134
Accumulated other comprehensive loss	(8,393)	(5,384)
Total UnitedHealth Group shareholders' equity	77,772	71,760
Total liabilities and shareholders' equity	$ 144,286	$ 125,289

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2022	2021	2020
Revenues:			
Investment and other income	$ 255	$ 494	$ 194
Total revenues	255	494	194
Operating costs:			
Operating costs	121	40	27
Interest expense	2,110	1,583	1,594
Total operating costs	2,231	1,623	1,621
Loss before income taxes	(1,976)	(1,129)	(1,427)
Benefit for income taxes	429	231	300
Loss of parent company	(1,547)	(898)	(1,127)
Equity in undistributed income of subsidiaries	21,667	18,183	16,530
Net earnings	20,120	17,285	15,403
Other comprehensive loss	(3,009)	(1,570)	(236)
Comprehensive income	$ 17,111	$ 15,715	$ 15,167

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2022	2021	2020
Operating activities			
Cash flows from operating activities	$ 14,754	$ 11,439	$ 8,842
Investing activities			
Issuances of notes to subsidiaries	(567)	(444)	(628)
Repayments of notes to subsidiaries	281	37	1,089
Cash paid for acquisitions	(20,728)	(4,953)	(7,706)
Return of capital to parent company	1,424	245	943
Capital contributions to subsidiaries	(570)	(747)	(43)
Cash received from dispositions	2,787	—	143
Cash flows used for investing activities	(17,373)	(5,862)	(6,202)
Financing activities			
Common stock repurchases	(7,000)	(5,000)	(4,250)
Proceeds from common stock issuances	1,253	1,355	1,440
Cash dividends paid	(5,991)	(5,280)	(4,584)
Proceed from (repayments of) short-term borrowings, net	732	(1,302)	872
Proceeds from issuance of long-term debt	14,819	6,933	4,864
Repayments of long-term debt	(3,015)	(3,150)	(3,150)
Proceeds from notes from subsidiaries	594	3,223	2,818
Other, net	(674)	(447)	(438)
Cash flows from (used for) financing activities	718	(3,668)	(2,428)
(Decrease) increase in cash and cash equivalents	(1,901)	1,909	212
Cash and cash equivalents, beginning of period	2,167	258	46
Cash and cash equivalents, end of period	$ 266	$ 2,167	$ 258
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,969	$ 1,575	$ 1,633
Cash paid for income taxes	4,298	3,050	4,185

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends and Capital Distributions. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $15.6 billion, $10.8 billion and $10.0 billion in 2022, 2021 and 2020, respectively. Additionally, $1.4 billion, $0.2 billion and $0.9 billion in cash were received as a return of capital to the parent company during 2022, 2021 and 2020, respectively.

3. Short-Term Borrowings and Long-Term Debt

Discussion of short-term borrowings and long-term debt can be found in Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data." Long-term debt obligations of the parent company do not include other financing obligations at subsidiaries which totaled $0.9 billion and $1.4 billion at December 31, 2022 and 2021.

Maturities of short-term borrowings and long-term debt for the years ending December 31 are as follows:

(in millions)	
2023	$ 2,925
2024	3,000
2025	3,050
2026	2,500
2027	2,925
Thereafter	43,502

UnitedHealth Group's parent company had notes payable to subsidiaries of $8.7 billion and $8.1 billion as of December 31, 2022 and 2021, respectively, which included on-demand features.

4. Commitments and Contingencies

Certain regulated subsidiaries are guaranteed by UnitedHealth Group's parent company in the event of insolvency. UnitedHealth Group's parent company also provides guarantees related to its service level under certain contracts. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2022, 2021 or 2020.

For a summary of commitments and contingencies, see Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Dated: February 24, 2023

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

UNITEDHEALTH GROUP INCORPORATED

By: /s/ ANDREW WITTY
Andrew Witty
Chief Executive Officer

Signature	Title	Date
/s/ ANDREW WITTY **Andrew Witty**	Director and Chief Executive Officer (principal executive officer)	February 24, 2023
/s/ JOHN REX **John Rex**	Executive Vice President and Chief Financial Officer (principal financial officer)	February 24, 2023
/s/ THOMAS ROOS **Thomas Roos**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 24, 2023
* **Timothy Flynn**	Director	February 24, 2023
* **Paul Garcia**	Director	February 24, 2023
* **Kristen Gil**	Director	February 24, 2023
* **Stephen Hemsley**	Director	February 24, 2023
* **Michele Hooper**	Director	February 24, 2023
* **F. William McNabb III**	Director	February 24, 2023
* **Valerie Montgomery Rice, M.D.**	Director	February 24, 2023
* **John Noseworthy, M.D.**	Director	February 24, 2023
*By /s/ KUAI LEONG **Kuai Leong** **As Attorney-in-Fact**		

UnitedHealth Group Form 10-K – 2021

Parent Company Audited Financial Statements

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2021

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE TRANSITION PERIOD FROM _____ TO _____

Commission File Number: 1-10864

UNITEDHEALTH GROUP®

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Delaware	**41-1321939**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota**	**55343**
(Address of principal executive offices)	**(Zip Code)**

(952) 936-1300
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $.01 par value	**UNH**	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒	Accelerated filer ☐	Non-accelerated filer ☐
Smaller reporting company ☐		Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2021 was $376,162,785,060 (based on the last reported sale price of $400.44 per share on June 30, 2021 as reported on the on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 31, 2022, there were 940,899,146 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2022 Annual Meeting of Shareholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

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PART I

ITEM 1. BUSINESS

OUR BUSINESSES

Overview

The terms "we," "our," "us," "its," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

UnitedHealth Group Incorporated is a health care and well-being company with a mission to help people live healthier lives and help make the health system work better for everyone.

Our two distinct, yet complementary business platforms—Optum and UnitedHealthcare—are working to help build a modern, high-performing health system through improved access, affordability, outcomes and experiences for the individuals and organizations we are privileged to serve.

The ability to analyze complex data and apply deep health care expertise and insights allows us to serve people, care providers, businesses, communities and governments with more innovative products and complete, end-to-end offerings for many of the biggest challenges facing health care today.

Optum combines clinical expertise, technology and data to empower people, partners and providers with the guidance and tools they need to achieve better health. Optum serves the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its Optum Health, Optum Insight and Optum Rx businesses. These businesses improve overall health system performance by optimizing care quality and delivery, reducing costs and improving consumer and provider experience, leveraging distinctive capabilities in data and analytics, pharmacy care services, health care operations, population health and health care delivery.

UnitedHealthcare offers a full range of health benefits, enabling affordable coverage, simplifying the health care experience, improving consumer health, advancing health equity and delivering access to high-quality care. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and individual consumers. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare Global provides health and dental benefits and hospital and clinical services to employer groups and individuals in South America, and through other diversified global health services.

We have four reportable segments:

- Optum Health;
- Optum Insight;
- Optum Rx; and
- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global.

Optum

Optum is an information and technology-enabled health services business serving the broad health care marketplace, including:

- Those who need care: consumers who need the right care, information, resources, products and engagement to improve their health, achieve their health goals and receive an improved patient experience that is personalized and holistic and delivered in all care settings, including in-home and virtually.

- Those who provide care: pharmacies, hospitals, physicians and other health care facilities seeking to improve the health system and reduce the administrative burden allowing for providers to focus time on patients leading to the best possible patient care and experiences while achieving better health outcomes at lower costs. Improved health outcomes are achieved by leveraging our clinical expertise, data and analytics to better predict, prevent and intercept consumers' health conditions and ensure they receive the best evidence-based care.
- Those who pay for care: employers; health plans; and state, federal and municipal agencies devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently and effectively, all while driving health equity so that every individual, family and community has access to the care they need.
- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines to improve care delivery and health outcomes.

Optum operates three business segments leveraging distinctive capabilities in health care delivery, population health, health care operations, data and analytics and pharmacy care services:

- Optum Health delivers care, care management, wellness and consumer engagement, and health financial services;
- Optum Insight offers data, analytics, research, consulting, technology and managed services solutions; and
- Optum Rx provides a diversified array of pharmacy care services.

Optum Health

Optum Health provides health and wellness care, addressing the physical, emotional and health-related financial needs of 100 million consumers, through a national health care delivery platform which engages people in the most appropriate care settings, including clinical sites, in-home and virtual. Optum Health delivers local primary, in-home, specialty, surgical and urgent care; helps patients and providers navigate and address complex, chronic and behavioral health needs; offers post-acute care planning services; and serves consumers and care providers through advanced, on-demand digital health technologies, such as telehealth and remote patient monitoring, and innovative health care financial services. Optum Health works directly with consumers, care delivery systems, providers, employers, payers, and government entities to provide high quality accessible and equitable care with improved outcomes and reduced total cost of care.

Optum Health enables care providers to transition from traditional fee-for-service payment models to performance-based delivery and payment models designed to improve patient health outcomes and experience through value-based care. Through strategic partnerships, alliances and ownership arrangements, Optum Health helps care providers adopt new approaches and technologies improving the coordination of care across providers to serve patients more comprehensively.

Optum Health offers its products on a risk basis, assuming responsibility for health care costs in exchange for a monthly premium, on an administrative fee basis, managing or administering products and services in exchange for a monthly fee, and on a fee-for-service basis, delivering medical services to patients in exchange for a contracted fee.

Optum Financial, including Optum Bank, serves consumers through 8 million health savings and other accounts and has more than $19 billion in assets under management as of December 31, 2021. During 2021, Optum Financial processed $264 billion in digital medical payments to physicians and other health care providers. Organizations across the health system rely on Optum Financial to manage and improve payment flows through its highly automated, scalable, digital payment systems. For financial services offerings, Optum Health charges fees and earns investment income on managed funds.

Optum Health sells its products primarily through its direct sales force, strategic collaborations and external producers in three key areas: employers, including large, mid-sized and small employers; payers including health plans, third-party administrators (TPAs), underwriter/stop-loss carriers and individual product intermediaries; and government entities including the U.S. Departments of Health and Human Services (HHS), Veterans Affairs, Defense, and other federal, state and local health care agencies.

Optum Insight

Optum Insight connects the health care system with services, analytics and platforms that make clinical, administrative and financial processes easier for all participants in the health care system. Hospital systems, physicians, health plans, state governments, life sciences companies and other organizations comprising the health care industry depend on Optum Insight to help them improve performance, reduce costs, advance quality, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system. Optum Insight serves the needs of health systems (such as physicians and hospital systems), health plans, state governments and life sciences companies.

Health Systems. Serves hospitals, physicians and other care providers to improve revenue and growth, better coordinate care and reduce administrative costs through technology and services to improve population health management, patient engagement, revenue cycle management and strategic growth plans.

Health Plans. Serves health plans by improving financial performance and enhancing outcomes through proactive analytics, a comprehensive payment integrity portfolio and technology-enabled and staff-supported risk and quality services. Optum Insight helps health plans navigate a dynamic environment defined by shifts in employer vs. government-sponsored coverage, the demand for affordable benefit plans and the need to leverage new technology to reduce complexity.

State Governments. Provides advanced technology and analytics services to modernize the administration of critical safety net programs, such as Medicaid, while improving cost predictability.

Life Sciences Companies. Combines data and analytics expertise with comprehensive technologies and health care knowledge to help life sciences companies, including those in pharmaceuticals and medical technology, adopt a more comprehensive approach to advancing therapeutic discoveries and improving clinical outcomes.

Many of Optum Insight's software and information products and professional services are delivered over extended periods, often several years. Optum Insight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with Optum Insight's customers. Optum Insight's aggregate backlog as of December 31, 2021 was approximately $22.4 billion, of which $12.1 billion is expected to be realized within the next 12 months. The aggregate backlog includes $8.9 billion related to affiliated agreements. Optum Insight's aggregate backlog as of December 31, 2020, was $20.2 billion.

Optum Insight's products and services are sold primarily through a direct sales force. Optum Insight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface Optum Insight's products with their applications.

Optum Rx

Optum Rx provides a full spectrum of pharmacy care services through its network of more than 67,000 retail pharmacies, through home delivery, specialty and community health pharmacies and through the provision of in-home and community-based infusion services. It also offers a direct-to-consumer business.

Optum Rx manages a broad range of prescription drug spend, including widely available retail drugs as well as limited and ultra-limited distribution drugs in oncology, HIV, pain management and ophthalmology. Optum Rx serves the growing pharmacy needs of people with behavioral health and substance use disorders. In 2021, Optum Rx managed $112 billion in pharmaceutical spending, including $45 billion in specialty pharmaceutical spending.

Optum Rx serves health benefits providers, large national employer plans, unions and trusts, purchasing coalitions and government entities. Optum Rx's sales distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

Optum Rx offers multiple clinical programs, digital tools and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner which are designed to promote better health outcomes, and to help target inappropriate utilization and non-adherence to medication. Optum Rx provides various utilization management, medication management, quality assurance, adherence and counseling programs to complement each client's plan design and clinical strategies. Optum Rx offers a distinctive approach to integrating the management of medical and pharmaceutical care by using data and advanced analytics to help improve comprehensive decision-making, elevate quality, close gaps in care and reduce costs for customers and people served.

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, creating a better health care experience for its customers and helping to control rising health care costs. UnitedHealthcare's market position is built on:

- strong local-market relationships;
- the breadth of product offerings, based upon extensive expertise in distinct market segments in health care;
- service and advanced technology, including digital consumer engagement;
- competitive medical and operating cost positions;
- effective clinical engagement; and
- innovation for customers and consumers.

UnitedHealthcare uses Optum's capabilities to help coordinate and provide patient care, improve affordability of medical care, analyze cost trends, manage pharmacy care services, work with care providers more effectively and create a simpler and more satisfying consumer and physician experience.

In the United States, UnitedHealthcare arranges for discounted access to care through networks which, as of December 31, 2021, include 1.5 million physicians and other health care professionals and more than 7,000 hospitals and other facilities.

UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under "Government Regulation" and in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers a comprehensive array of consumer-oriented health benefit plans and services nationwide for large national employers, public sector employers, mid-sized employers, small businesses, and individual consumers. As of December 31, 2021, UnitedHealthcare Employer & Individual provides access to medical services for 26.6 million people on behalf of our customers and alliance partners, including employer customers, serving people across all 50 states, the District of Columbia and most U.S. territories. Products are offered through affiliates licensed as insurance companies, health maintenance organizations (HMOs), or TPAs. Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium which is typically a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers who elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing

and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision professionals.

The consolidated purchasing capacity represented by the individuals served by UnitedHealth Group makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals and facilities. UnitedHealthcare Employer & Individual has relationships with network care providers who integrate data and analytics, implement value-based payment arrangements and care management programs that enable us to jointly better manage health care and improve quality across populations. UnitedHealthcare Employer & Individual's comprehensive and integrated pharmacy care services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs offering improved value and outcomes, helping consumers take actions to improve their health and supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

UnitedHealthcare Employer & Individual typically distributes its products through a variety of channels, dependent upon the specific product, including: through consultants or direct sales, in collaboration with brokers and agents, through wholesale agents or agencies who contract with health insurance carriers to distribute individual or group benefits, through professional employer organizations and associations and through both multi-carrier and its own proprietary private exchange marketplaces.

UnitedHealthcare Employer & Individual's diverse product portfolio offers employers a continuum of benefit designs, price points and approaches to consumer engagement which provides the flexibility to meet a full spectrum of their coverage needs. UnitedHealthcare Employer & Individual's major product families include consumer engagement products, such as high-deductible consumer driven benefit plans and a variety of innovative consumer centric products; traditional products; clinical and pharmacy products; and specialty benefits, such as vision, dental, hearing, accident protection, critical illness, disability and hospital indemnity offerings.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on offering type (risk-based or self-funded), line of business (such as small business, key accounts, public sector, national accounts or individual consumers) and clinical need. UnitedHealthcare Employer & Individual's clinical programs include: wellness programs, decision support, utilization management, case and disease management, complex condition management, on-site programs, incentives to reinforce positive behavior change, mental health/substance use disorder management and employee assistance programs.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services, as well as services dealing with chronic disease and other specialized issues common among older people. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing market segment, providing products and services in all 50 states, the District of Columbia and most U.S. territories. UnitedHealthcare Medicare & Retirement has distinct benefit designs, pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products allowing people choice in obtaining the health coverage and services they need as their circumstances change. UnitedHealthcare Medicare & Retirement is positioned to serve seniors who find affordable, network-based care provided through Medicare Advantage plans to meet their unique health care needs. For those who prefer traditional fee-for-service Medicare, UnitedHealthcare Medicare & Retirement offers both Medicare Supplement and Medicare Prescription Drug Benefit (Medicare Part D) programs to expand their government-sponsored Medicare by providing additional benefits and coverage options. UnitedHealthcare Medicare & Retirement offerings include care management and health system navigator services, clinical management programs, nurse health line services, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients, including AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through agents, employer groups and digital channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries through the Medicare Advantage program administered by the Centers for Medicare & Medicaid Services (CMS), including Medicare Advantage HMO plans, Preferred Provider Organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, monthly consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which individuals reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. Medicare Advantage plans are designed to compete at the local level, taking into account consumer and care provider preferences, competitor offerings, our quality and cost initiatives, our historical financial results and the long-term payment rate outlook for each geographic area. UnitedHealthcare Medicare & Retirement served 6.5 million people through its Medicare Advantage products as of December 31, 2021.

UnitedHealthcare Medicare & Retirement's senior-focused care management model operates at a medical cost level below traditional Medicare, while helping seniors live healthier lives. We have continued to enhance our offerings, focusing on more digital and physical care resources in the home, expanding our concierge navigation services and enabling the home as a safe and effective setting of care. For example, through our HouseCalls program, nurse practitioners performed more than 2.1 million clinical preventive home care visits in 2021 to address unmet care opportunities and close gaps in care. Our Navigate4Me program provides a single point of contact and a direct line of support for individuals as they go through their health care experiences. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software and digital therapeutics for remote monitoring enabling clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information bridging capabilities across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify people at high risk and enable care managers to create individualized care plans to help them obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries through its Medicare Advantage and stand-alone Medicare Part D plans. The stand-alone Medicare Part D plans address a large spectrum of people's needs and preferences for their prescription drug coverage, including low-cost prescription options. Each of the plans includes the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2021, UnitedHealthcare enrolled 9.5 million people in the Medicare Part D programs, including 3.7 million individuals in stand-alone Medicare Part D plans, with the remainder in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving 4.4 million seniors nationwide through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at diverse price points. These products cover various levels of coinsurance and deductible gaps to which seniors are exposed in the traditional Medicare program.

Premium revenues from CMS represented 36% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2021, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs caring for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage, typically in exchange for a monthly premium per member from the state program. UnitedHealthcare Community & State's primary customers oversee

Medicaid plans, including Temporary Assistance to Needy Families (TANF); Children's Health Insurance Programs (CHIP); Dual SNPs (DSNPs); Long-Term Services and Supports (LTSS); Aged, Blind and Disabled; and other federal, state and community health care programs. As of December 31, 2021, UnitedHealthcare Community & State participated in programs in 32 states and the District of Columbia, and served 7.7 million people; including nearly 1.4 million people through Medicaid expansion programs in 18 states under the Patient Protection and Affordable Care Act (ACA).

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation, including the state's commitment and consistency of support for its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates, commensurate with medical cost trends.

These health plans and care programs are designed to address the complex needs of the populations they serve, including the chronically ill, people with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in medically underserved areas and are less likely to have a consistent relationship with the medical community or a care provider. They also often face significant social and economic challenges.

UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group locally, supporting effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing national and local market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care and often addresses other social determinants affecting people's health status and health system usage.

Although approximately 80% of the people in state Medicaid programs are served by managed care, there remains significant growth opportunity as this population represents only approximately 55% of total Medicaid spending. UnitedHealthcare Community & State's business development opportunities include entering fee-for-service markets converting to managed care; and growing in existing managed care markets, including state expansions to populations with more complex needs requiring more sophisticated models of care, including DSNP and LTSS programs. Our offerings to state expansion cover more medically complex populations, including integrated care management of physical, behavioral, long-term care services and supports, and social services by applying strong data analytics and community-based collaboration.

UnitedHealthcare Community & State continues to evolve its clinical model to enhance quality and the clinical experience for the people it serves. The model enables UnitedHealthcare Community & State to quickly identify the people who could benefit most from more highly coordinated care.

UnitedHealthcare Global

UnitedHealthcare Global serves 7.8 million people with medical and dental benefits, typically in exchange for a monthly premium per member, residing principally in Brazil, Chile, Colombia and Peru, but also in more than 150 other countries. UnitedHealthcare Global serves multinational and local businesses, governments, insurers and individuals and their families through health insurance plans for local populations, care delivery services, benefit plans and risk and assistance solutions. UnitedHealthcare Global offers health care delivery in our principal markets through over 50 hospitals, and more than 200 outpatient and ambulatory clinics and surgery centers to UnitedHealthcare Global members and consumers served by the external payer market.

In Brazil, Amil provides health benefits to 3.4 million people and dental benefits to nearly 2.3 million people. Empresas Banmédica provides health benefits and health care services to approximately 2.1 million people in Chile, Colombia and Peru. Lusíadas Saúde provides clinical services to people in Portugal through an owned network of hospitals and outpatient clinics.

GOVERNMENT REGULATION

Our businesses are subject to comprehensive U.S. federal and state and international laws and regulations. We are regulated by agencies which generally have discretion to issue regulations and interpret and enforce laws and rules. The regulations can vary significantly among jurisdictions and the interpretation of them are subject to frequent change. Domestic U.S. and international governments continue to consider and enact various legislative and regulatory proposals which could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our businesses.

If we fail to comply with, are alleged to have failed to comply with, or fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our compliance with federal, state and international laws and regulations.

U.S. Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations, including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amounts of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to medical loss ratios (MLRs) and risk adjustment data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance, and the regulatory environment with respect to these programs is complex. In addition, our businesses are subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriate reduction or limitation of health care services, anti-money laundering, securities and antitrust compliance.

Privacy, Security and Data Standards Regulation. Certain of our operations are subject to regulation under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), which apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets and for the privacy and security of protected health information.

Our businesses must comply with the Health Information Technology for Economic and Clinical Health Act (HITECH) which regulates matters relating to privacy, security and data standards. HITECH imposes requirements on uses and disclosures of health information; includes contracting requirements for HIPAA business associate agreements; extends parts of HIPAA privacy and security provisions to business associates; adds federal data breach notification requirements for covered entities and business associates and reporting requirements to HHS and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthens enforcement and imposes higher financial penalties for HIPAA violations and, in certain cases, imposes criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate.

The use and disclosure of individually identifiable health data by our businesses are also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and generally prescribe safeguards for the protection of personal information. Neither the GLBA nor HIPAA

privacy regulations preempt more stringent state laws and regulations, which may apply to us, as discussed below. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations subject to interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee health benefit plans, particularly those who maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for administration of benefits, claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations, which require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. We are required to maintain a risk management framework and file a confidential self-assessment report with state insurance regulators. We file reports annually with Connecticut, our lead regulator, and with New York, as required by the state's regulation.

Our health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports describing capital structure, ownership, financial condition, certain affiliated transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material affiliated transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, Managed Care Organization (MCO), utilization review (UR), TPA, pharmacy care services, durable medical equipment or care provider-related regulations and licensure requirements. These regulations differ from state to state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. There are laws and regulations which set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distribution laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies which oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our beneficiaries dually eligible for Medicare and Medicaid. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

State Privacy and Security Regulations. A number of states have adopted laws and regulations which may affect our privacy and security practices, such as state laws governing the use, disclosure and protection of social security numbers and protected health information or which are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to meet minimum cyber-security standards and notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Different approaches to state privacy and insurance regulation and varying enforcement philosophies may materially and adversely affect our ability to standardize

our products and services across state lines. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws prohibiting specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from engaging in fee-splitting practices, which involve sharing in the fees or revenues of a professional practice. These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation. The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Pharmacy and Pharmacy Benefits Management (PBM) Regulations

Optum Rx's businesses include home delivery, specialty and compounding pharmacies, as well as clinic-based pharmacies which must be licensed as pharmacies in the states in which they are located. Certain of our pharmacies must also register with the U.S. Drug Enforcement Administration (DEA) and individual state controlled substance authorities to dispense controlled substances. In addition to adhering to the laws and regulations in the states where our pharmacies are located, we also are required to comply with laws and regulations in some non-resident states where we deliver pharmaceuticals, including those requiring us to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our pharmacies to follow the laws of the state in which the pharmacies are located, but some non-resident states also require us to comply with their laws where pharmaceuticals are delivered. Additionally, certain of our pharmacies which participate in programs for Medicare and state Medicaid providers are required to comply with applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our pharmacy care services businesses.

Federal and state legislation of PBM activities affects both our ability to limit access to a pharmacy provider network or remove network providers. Additionally, many states limit our ability to manage and establish maximum allowable costs for generic prescription drugs. With respect to formulary services, a number of government entities, including CMS, HHS and state departments of insurance, regulate the administration of prescription drug benefits offered through federal or state exchanges. Many states also regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. These regulations could limit or preclude (i) certain plan designs, (ii) limited networks, (iii) requirements to use particular care providers or distribution channel, (iv) copayment differentials among providers and (v) formulary tiering practices.

Legislation seeking to regulate PBM activities introduced or enacted at the federal or state level could impact our business practices with others in the pharmacy supply chain, including pharmaceutical manufacturers and network providers. Additionally, organizations like the NAIC periodically issue model regulations while credentialing organizations, like the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), may establish standards impacting PBM pharmacy activities. Although these model regulations and standards do not have the force of law, they may influence states to adopt their recommendations and impact the services we deliver to our clients.

Consumer Protection Laws

Certain of our businesses participate in direct-to-consumer activities and are subject to regulations applicable to online communications and other general consumer protection laws and regulations such as the Federal Tort Claims Act, the Federal Postal Service Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws.

Certain laws, such as the Telephone Consumer Protection Act, give the FTC, the Federal Communications Commission (FCC) and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide

consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

Non-U.S. Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes vary from jurisdiction to jurisdiction. In addition, our non-U.S. businesses and operations are subject to U.S. laws regulating the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health care company, we operate in highly competitive markets across the full expanse of health care benefits and services, including organizations ranging from startups to highly sophisticated Fortune 50 global enterprises, for-profit and non-profit companies, and private and government-sponsored entities. New entrants and business combinations also contribute to a dynamic and competitive environment. We compete fundamentally on the quality and value we provide to those we serve which can include elements such as product and service innovation; use of technology; consumer and provider engagement and satisfaction; and sales, marketing and pricing. See Part I, Item 1A, "Risk Factors" for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, Optum and UnitedHealthcare names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim any proprietary interest in the marks and names of others.

HUMAN CAPITAL RESOURCES

Our 350,000 employees, as of December 31, 2021, including nearly 135,000 clinical professionals, are guided by our mission to help people live healthier lives and help make the health system work better for everyone. Our mission and cultural values of integrity, compassion, relationships, innovation and performance align with our long-term business strategy to increase access to care, make care more affordable, enhance the care experience and improve health outcomes. Our mission and values attract individuals who are determined to make a difference—individuals whose talent, innovation, engagement and empowerment are critical in our ability to achieve our mission. Similar to other businesses, in 2021 we have experienced moderately higher levels of employment attrition and COVID-19 continues to drive unplanned absences, but due to increased recruiting capacity and upgraded digital capabilities our workforce continues to be able to meet the needs of those we serve.

We are committed to developing our people and culture by creating an inclusive environment where people of diverse backgrounds, experiences and perspectives make us better. Our approach is data-driven and leader led, including enterprise and business scorecards ensuring our leaders are accountable for a consistent focus on hiring, developing, advancing and retaining diverse talent. We have embedded inclusion and diversity throughout our culture, including in our talent acquisition and talent management practices; leadership development; careers; learning and skills; and systems and processes. We strive to maintain a sustainable and diverse talent pipeline by building strong strategic partnerships and outreach through early career programs, internships and apprenticeships. We support career coaching, mentorship and accelerated leadership development programs to ensure mobility and advancement for our diverse talent. To foster an engaged workforce and an inclusive culture, we invest in a broad array of learning and culture development programs. We rely on a shared leadership framework, which clearly and objectively defines our expectations, enables an environment where everyone has the opportunity to learn and grow, and helps us identify, develop and deploy talent to help achieve our mission.

We prioritize pay equity by regularly evaluating and reviewing our compensation practices by gender, ethnicity and race. Receiving on-going feedback from our team members is another way to strengthen and reinforce a culture of inclusion. Our Employee Experience Index measures an employee's sense of commitment and belonging to the Company and is a metric in the Stewardship section of our annual incentive plan. Our Sustainability Report, which can be accessed on our website at www.unitedheatlhgroup.com, provides further details on our people and culture.

INFORMATION ABOUT OUR EXECUTIVE OFFICERS

The following sets forth certain information regarding our executive officers as of February 10, 2022, including the business experience of each executive officer during the past five years:

Name	Age	Position
Andrew P. Witty	57	Chief Executive Officer
Dirk C. McMahon	62	President and Chief Operating Officer
John F. Rex	60	Executive Vice President and Chief Financial Officer
Patricia L. Lewis	60	Executive Vice President and Chief Human Resources Officer
Thomas E. Roos	49	Senior Vice President and Chief Accounting Officer
Marianne D. Short	70	Executive Vice President and Chief Legal Officer
Brian R. Thompson	47	Chief Executive Officer of UnitedHealthcare

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Mr. Witty has served as Chief Executive Officer and a member of the Board of Directors of UnitedHealth Group since February 2021. Previously, Mr. Witty served as Chief Executive Officer of Optum beginning in July 2018, President of UnitedHealth Group from November 2019 to February 2021 and as a UnitedHealth Group director from August 2017 to March 2018. From April 2020 to November 2020, Mr. Witty took an unpaid leave of absence to serve as a Global Envoy for the World Health Organization's COVID-19 efforts. Prior to joining UnitedHealth Group, he was Chief Executive Officer and a board member of GlaxoSmithKline, a global pharmaceutical company, from 2008 to April 2017.

Mr. McMahon has served as President and Chief Operating Officer of UnitedHealth Group since February 2021. In addition, Mr. McMahon previously served as Chief Executive Officer of UnitedHealthcare June 2019 to April 2021, President and Chief Operating Officer of Optum from April 2017 to June 2019 and Executive Vice President, Operations at UnitedHealth Group from November 2014 to April 2017. Mr. McMahon also served as Chief Executive Officer of Optum Rx from November 2011 to November 2014. Prior to 2011, he held various positions in UnitedHealthcare in operations, technology and finance.

Mr. Rex has served as Executive Vice President and Chief Financial Officer of UnitedHealth Group since June 2016. From March 2012 to June 2016, Mr. Rex served as Executive Vice President and Chief Financial Officer of Optum. Prior to joining Optum in 2012, Mr. Rex was a Managing Director at JP Morgan, a global financial services firm.

Ms. Lewis has served as Executive Vice President and Chief Human Resources Officer of UnitedHealth Group since October 2019. Prior to joining UnitedHealth Group, Ms. Lewis served at Lockheed Martin Corporation, a global security and aerospace company, where she was Senior Vice President and Chief Human Resources Officer from December 2014 to October 2019. Prior to joining Lockheed Martin Corporation in 2011, Ms. Lewis held various positions in Human Resources at International Business Machines Corporation, a global technology company, and DuPont De Nemours, Inc, a global diversified chemicals company. Ms. Lewis currently serves as a director of Lear, Inc.

Mr. Roos has served as Senior Vice President and Chief Accounting Officer of UnitedHealth Group since August 2015. Prior to joining UnitedHealth Group, Mr. Roos was a Partner at Deloitte & Touche LLP, an independent registered public accounting firm, from September 2007 to August 2015.

Ms. Short has served as Executive Vice President and Chief Legal Officer of UnitedHealth Group from January 2013 to January 2021 and from June 2021 to present. Prior to joining UnitedHealth Group, Ms. Short served as the Managing Partner at Dorsey & Whitney LLP, an international law firm, from January 2007 to December 2012.

Mr. Thompson has served as Chief Executive Officer of UnitedHealthcare since April 2021. Prior to this role, he served as Chief Executive Officer of UnitedHealthcare's government programs including Medicare & Retirement and Community & State from 2017 to 2021; as Chief Financial Officer of UnitedHealthcare's Employer & Individual and Medicare & Retirement businesses from 2010 to 2017; as Financial Controller of UnitedHealthcare's Employer & Individual business from 2008 to 2010; and as Director, Corporate Development from 2004 to 2008.

Additional Information

Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at www.unitedhealthgroup.com to learn more about our company. From the site you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our certificate of incorporation and bylaws; corporate governance policies, including our Principles of Governance; Board of Directors Committee Charters; Code of Conduct; and annual sustainability report. We make periodic reports and amendments available, free of charge, on our website, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Equiniti (EQ), can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: EQ Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, or telephone (800) 401-1957 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words "believe," "expect," "intend," "estimate," "anticipate," "forecast," "outlook," "plan," "project," "should" or similar words or phrases are intended to identify such forward-looking statements. These statements are intended to take advantage of the "safe harbor" provisions of the PSLRA. These forward-looking statements involve risks and uncertainties which may cause our actual results to differ

materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement in this report speaks only as of the date of this report and, except as required by law, we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business, which investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other public filings or statements we make may turn out to be wrong. Our forward-looking statements can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. Many factors discussed below will be important in determining our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions which are difficult to predict or quantify.

Risks Related to Our Business and Our Industry

We are subject to risks associated with public health crises, large-scale medical emergencies and pandemics, such as the COVID-19 pandemic, which could continue to have a material adverse effect on our business, results of operations, financial condition and financial performance.

The ongoing COVID-19 pandemic continues to impact health systems, businesses, governments and customer and consumer activities. The future impact to our business is primarily dependent upon the ultimate pacing, intensity and duration of the crisis, the severity of new variants of the COVID-19 virus, and the effectiveness and extent of administration of vaccinations and treatments, factors which remain uncertain at this time. These factors continue to affect the related treatment, testing, coverage and other services we provide for the people we serve. We may experience an increase in medical care costs as people seek care which was deferred during the pandemic and individuals with chronic conditions may require additional care needs resulting from missed treatments. The premiums and fees we charge, including premiums dependent upon documented health conditions, may not be sufficient to cover the medical and administrative costs associated with COVID-19 and other care services. Similarly, state and federal mandates for coverage may result in additional incurred expenses that are not associated with increases in government reimbursement (such as requirements for insurers to cover at-home COVID-19 testing).We have experienced and may continue to experience reduced demand for certain services Optum provides to care providers, health plans and employers as a result of reduced clinical and claims activity and changes in business priorities resulting from COVID-19. In addition, our care delivery business may continue to be adversely impacted by COVID-19 infections and exposures affecting providers we employ, resulting in reduced capacity to handle demand for care and related partial or full closures of our facilities. Our non-clinical workforce may also be adversely impacted by COVID-19 infections and exposures impacting our business operations.

The COVID-19 pandemic has resulted in some of our customers having to temporarily or permanently close or severely curtail their operations, and unfavorable economic conditions resulting from the pandemic may continue to impact our clients, customers, health care providers, third party vendors and federal and state entities and programs. Among other impacts, we have experienced and may continue to experience loss of commercial and pharmacy care services members due to customer reductions in workforce and an adverse impact on the timing and collectability of premium payments. In addition, governments have modified, and may continue to modify, regulatory standards around various aspects of health care in response to COVID-19, which may adversely affect our ability to ensure timely compliance and meet various contractual obligations.

Further disruptions in public and private infrastructure, including supply chains providing medical supplies and pharmaceutical products, could disrupt our business operations or increase our operating costs. Additionally, the enactment of emergency powers by governments could disrupt our business operations, including by restricting pharmaceuticals or other supplies, and could increase the risk of shortages of necessary items.

Although we cannot predict the pacing, intensity and duration of COVID-19, the pandemic's disruption to business activities, employment and economic effects, and near and long-term impacts on the patterns of care and services across the healthcare system could continue to have material and adverse effects on our business, results of operations, financial position or cash flows.

If we fail to estimate, price for and manage our medical costs or set benefit designs in an effective manner, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our products depends in large part on our ability to predict, price for and effectively manage medical costs. Our Optum Health business negotiates value-based arrangements with commercial third-party payers which are also included in premium revenues. Under a typical arrangement, Optum Health receives a fixed percentage of a third-party payer's premiums to cover all or a defined portion of the medical costs provided to members. Premium revenues from risk-based products comprise nearly 80% of our total consolidated revenues. If we fail to predict accurately, or effectively price for or manage, the costs of providing care under risk-based arrangements, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of competitive provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies and Medicaid contracts is typically based on a fixed monthly rate per individual served for a 12-month period and is generally priced one to six months before the contract commences. Our revenue on certain Medicare policies is based on bids submitted to CMS in June the year before the contract year. Although we base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, large-scale medical emergencies, the potential effects of climate change, pandemics, such as COVID-19, the introduction of new or costly drugs, treatments and technology, new treatment guidelines, newly mandated benefits or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2021 medical costs for commercial insured products had been 1% higher than our actual medical costs, without proportionally higher revenues from such products, our annual net earnings for 2021 would have been reduced by approximately $330 million, excluding any offsetting impact from risk adjustment or from reduced premium rebates due to minimum MLRs.

In addition, the financial results we report for any particular period include estimates of costs incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove inaccurate, our results of operations could be materially and adversely affected.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our business depends on the integrity and timeliness of the data we use to serve our members, customers and health care professionals and to operate our business. The volume of health care data generated, and the uses of data, including electronic health records, are rapidly expanding. Our ability to implement new and innovative services, price adequately our products and services, provide effective service to our customers in an efficient and uninterrupted fashion, and report accurately our results of operations depends on the integrity of the data in our information systems. In addition, connectivity among technologies is becoming increasingly important and recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences. If the data we rely upon to run our businesses is found to be inaccurate or unreliable or if we

fail to maintain or protect our information systems and data integrity effectively, we could experience failures in our health, wellness and information technology products; lose existing customers; have difficulty attracting new customers; experience problems in determining medical cost estimates and establishing appropriate pricing; have difficulty preventing, detecting and controlling fraud; have disputes with customers, physicians and other health care professionals; become subject to regulatory sanctions or penalties; incur increases in operating expenses; or suffer other adverse consequences.

We periodically consolidate, integrate, upgrade and expand our information systems' capabilities as a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions. Our process of consolidating the number of systems we operate, upgrading and expanding our information systems' capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology may not be successful. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install software products which may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to health data and the health information technology market may alter the competitive landscape or present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we sustain cyber-attacks or other privacy or data security incidents resulting in security breaches disrupting our operations or resulting in the unintended dissemination of protected personal information or proprietary or confidential information, we could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences.

We routinely process, store and transmit large amounts of data in our operations, including protected personal information subject to privacy, security or data breach notification laws, as well as proprietary or confidential information relating to our business or third parties. Some of the data we process, store and transmit may be outside of the United States due to our information technology systems and international business operations. We are regularly the target of attempted cyber-attacks and other security threats and may be subject to breaches of the information technology systems we use. We have programs in place which are intended to detect, contain and respond to data security incidents and provide employee awareness training regarding phishing, malware and other cyber risks to protect against cyber risks and security breaches. However, because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and are increasing in sophistication, we may be unable to anticipate these techniques, detect breaches for long periods of time or implement adequate preventive measures. Experienced computer programmers and hackers may be able to penetrate our security controls and access, misappropriate or otherwise compromise protected personal information or proprietary or confidential information or that of third parties, create system disruptions or cause system shutdowns, negatively affecting our operations. They also may be able to develop and deploy viruses, worms and other malicious software programs attacking our systems or otherwise exploit any security vulnerabilities. Hardware, software, or applications we develop or procure from third parties may contain defects in design or manufacture or other problems which could unexpectedly compromise information security. In addition, we are subject to heightened vulnerability to cybersecurity attacks associated with increased numbers of employees working from home. Our facilities and services may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; financial fraud schemes; misplaced or lost data; human error; malicious social engineering; or other events which could negatively affect our systems, our customers' data, proprietary or confidential information relating to our business or third parties, or our operations. In certain circumstances we may rely on third-party vendors to process, store and transmit large amounts of data for our business whose operations are subject to similar risks.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be material. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service and loss of existing or potential customers. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information, proprietary information or confidential information about us or our customers or other third parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, result in litigation and liability, including regulatory penalties, for us, damage our brand and reputation, or otherwise harm our business.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses face significant competition in all of the geographic markets in which we operate. In particular geographies or segments, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; lower profit margin or financial return expectations; or other factors which give such competitors a competitive advantage. Our competitive position may also be adversely affected by significant merger and acquisition activity in the industries in which we operate, both among our competitors and suppliers. Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability.

In addition, our success in the health care marketplace will depend on our ability to develop and deliver innovative and potentially disruptive products and services to satisfy evolving market demands. If we do not continue to innovate and provide products and services, which are useful and relevant to health care payers, consumers and our customers, we may not remain competitive, and we risk losing market share to existing competitors and disruptive new market entrants. For example, new direct-to-consumer business models from competing businesses may make it more difficult for us to directly engage consumers in the selection and management of their health care benefits and health care usage. We may face challenges from new technologies and market entrants which could affect our existing relationship with health plan enrollees in these areas. Any failure by us to continue to develop innovative care models, including accelerating the transition of care to value-based models and expanding access to virtual care, could result in competitive disadvantages and loss of market share. Additionally, our competitive position could be adversely affected by a failure to develop satisfactory data and analytics capabilities or provide services focused on these capabilities to our clients. Our business, results of operations, financial position and cash flows could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we fail to realize competitive advantages resulting from collaboration between our businesses, if we are unable to innovate and deliver products and services demonstrating value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

If we fail to develop and maintain satisfactory relationships with health care payers, physicians, hospitals and other service providers, our business could be materially and adversely affected.

We depend substantially on our continued ability to contract with health care payers (as a service provider to those payers), as well as physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and other service providers at competitive prices. Any failure by us to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes, which may be costly, divert management's attention from our operations and result in negative publicity.

In any particular market, physicians and health care providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher medical costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician and hospital

organizations or multi-specialty physician groups, may have significant market positions or near monopolies which could result in diminished bargaining power on our part. In addition, ACOs; practice management companies (which aggregate physician practices for administrative efficiency); and other organizational structures adopted by physicians, hospitals and other care providers may change the way in which these providers do business with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our business, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

Our health care benefits businesses have risk-based arrangements with some physicians, hospitals and other health care providers. These arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent a risk-based health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the arrangement, we may be held responsible for unpaid health care claims which should have been the responsibility of the health care provider and for which we have already paid the provider. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with which we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers render services to our members who do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in other cases the amount is either not defined or is established by a standard which does not clearly specify dollar terms. In some instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with us.

The success of some of our businesses, including Optum Health and UnitedHealthcare Global, depend on maintaining satisfactory relationships with physicians as our employees, independent contractors or joint venture partners. The physicians who practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. We face and will likely continue to face heightened competition in the markets where we operate to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with competitors of UnitedHealthcare. Our businesses could suffer if our affiliated physician organizations fail to maintain relationships with these companies, or fail to adequately price their contracts with these third-party payers.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and certain health care providers are customers of our Optum businesses. Physicians also provide medical services at facilities owned by our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

We are routinely subject to various legal actions, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

We are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include matters related to health care benefits coverage and payment claims (including disputes with enrollees, customers and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims (including claims related to the delivery of health care

services, such as medical malpractice by staff at our affiliates' facilities, or by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks, including as a result of a failure to adhere to applicable clinical, quality and/or patient safety standards), antitrust claims (including as a result of changes in the enforcement of antitrust laws), whistleblower claims (including claims under the False Claims Act or similar statutes), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. In addition, certain of our pharmacy services operations are subject to the clinical quality, patient safety and other risks inherent in the dispensing, packaging and distribution of drugs, including claims related to purported dispensing and other operational errors. We may also be party to certain class action lawsuits brought by health care professional groups and consumers. We operate in jurisdictions outside of the United States where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. Any failure by us to adhere to the laws and regulations applicable to our businesses could subject us to civil and criminal penalties.

We are largely self-insured with regard to litigation risks, including claims of medical malpractice against our affiliated physicians and us. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible the level of actual losses will significantly exceed the liabilities recorded. Additionally, physicians and other healthcare providers have become subject to an increasing number of legal actions alleging medical malpractice and general professional liabilities. Even in states that have imposed caps on damages for such actions, litigants are seeking recoveries under new theories of liability that might not be subject to the caps on damages. Many of these actions involve large claims and significant defense costs and, if these actions are asserted against us, could result in substantial monetary damages or damage to our reputation.

We cannot predict the outcome of significant legal actions in which we are involved and are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in some markets and businesses.

Any failure by us to manage successfully our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions or relationships domestically or outside the United States could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated which in turn could adversely impact our reputation, business and results of operations. Further, if we fail to identify and successfully complete transactions, which further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows.

Success in completing acquisitions is also dependent on effectively integrating the acquired business into our existing operations, including our internal control environment and culture, or otherwise leveraging its operations which may present challenges different from those presented by organic growth and may be difficult for us to manage. In addition, even with appropriate diligence, pre-acquisition practices of an acquired business may expose us to legal challenges and investigations. For example, in January 2021, an indictment for alleged violations of antitrust laws was issued by the DOJ against our subsidiary, Surgical Care Affiliates (SCA), based on conduct alleged to have begun more than five years prior to our acquisition. We are vigorously defending this lawsuit, but if SCA is found liable, we may be subject to criminal fines or reputational harm. If we cannot successfully integrate these acquisitions and realize contemplated revenue growth opportunities

and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we expand and operate our business outside of the United States, we are presented with challenges differing from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, languages, business, labor and cultural practices and regulatory environments. Adapting to these challenges could require us to devote significant senior management attention and other resources to the acquired businesses before we realize anticipated synergies or other benefits from the acquired businesses. These challenges vary widely by country and, outside of the United States, may include political instability, government intervention, discriminatory regulation and currency exchange controls or other restrictions, which could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate, or converting local currencies we hold into U.S. dollars or other currencies. If we are unable to manage successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our shareholders' equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through nonexclusive producers and consultants for whose services and allegiance we must compete. Our sales would be materially and adversely affected if we are unable to attract, retain and support such independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commission levels.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment during the early stages of the COVID-19 pandemic has caused lower enrollment or lower rates of renewal in our employer group benefits and pharmacy services plans. Unfavorable economic conditions also have caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retroactively to apply to payments already negotiated or received from the government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on health insurance and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, hospitals, care providers, employers and others which could, in turn, materially and adversely affect Optum's financial results.

Our failure to attract, develop, retain, and manage the succession of key employees and executives could adversely affect our business, results of operations and future performance.

We are dependent on our ability to attract, develop and retain qualified employees and executives, including those with diverse backgrounds, experiences and skill sets, to operate and expand our business. Experienced and highly skilled employees and executives in the health care and technology industries are in high demand and the market for their services is extremely competitive. We may have difficulty in replacing key executives because of the limited number of qualified individuals in these industries with the breadth of skills and experience required to operate and successfully expand our business. Adverse changes to our corporate culture, which seeks to foster integrity, compassion, relationships, innovation and performance, could harm our business operations and our ability to retain key employees and executives. While we have development and succession plans in place for our key employees and executives, these plans do not guarantee the services of our key employees and executives will continue to be available to us. If we are unable to attract, develop, retain and effectively manage the development and succession plans for key employees and executives, our business, results of operations and future performance could be adversely affected.

Our investment portfolio may suffer losses which could adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities which constitute the vast majority of the fair value of our investments as of December 31, 2021. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily issuers of our investments in corporate and municipal bonds), could reduce our investment income and require us to write down the value of our investments which could adversely affect our profitability and equity.

Our investments may not produce total positive returns and we may sell investments at prices which are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have an adverse effect on our results of operations and the capital position of our regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, equity and credit ratings could be materially and adversely affected.

As of December 31, 2021, our goodwill and other intangible assets had a carrying value of $86 billion, representing 40% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses we acquire perform in a manner inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and equity in the period in which the impairment occurs. A material decrease in equity could, in turn, adversely affect our credit ratings.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees and third parties, and our trademarks, trade secrets, copyrights and patents to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, and we expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this industry segment grows. Such litigation and misappropriation of our proprietary

information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength and debt ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used by customers and creditors. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. We may not be able to maintain our current credit ratings in the future. Any downgrades in our credit ratings could materially increase our costs of or ability to access funds in the debt capital markets and otherwise materially increase our operating costs.

Risks Related to the Regulation of Our Business

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related regulations and licensure requirements. Under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies which write the same line or similar lines of business. Any such assessment could expose our insurance entities and other insurers to the risk they would be required to pay a portion of an impaired or insolvent insurance company's claims through state guaranty associations.

Certain of our businesses provide products or services to government agencies. For example, some of our Optum and UnitedHealthcare businesses hold government contracts or provide services related to government contracts and are subject to U.S. federal and state and non U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims and other laws and regulations governing government contractors and the use of government funds. Our relationships with these government agencies are subject to the terms of contracts we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies which might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations distinct from those faced by our insurance and HMO subsidiaries, some of which could impact our relationships with physicians, hospitals and customers. These regulations include state telemedicine regulations; debt collection laws; banking regulations; distributor and producer licensing requirements; state corporate practice of medicine doctrines; fee-splitting rules; and health care facility licensure and certificate of need requirements. These risks and uncertainties may materially and adversely affect our ability to market or provide our products and services, or to do so at targeted operating margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our businesses and interpretations of those laws and rules are subject to frequent change. For example, legislative, administrative and public policy changes to the ACA have been and likely will continue to be considered, and we cannot predict if the ACA will be further modified. Litigation challenges have been brought seeking to invalidate the ACA in whole or in part and future litigation challenges are possible. Further, the integration into our businesses of entities we acquire may affect the way in which existing laws and rules apply to us, including by subjecting us to laws and rules which did

not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our businesses could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We also must obtain and maintain regulatory approvals to market many of our products and services, increase prices for certain regulated products and services and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on all proposed rate increases on many of our products to HHS for monitoring purposes. Geographic and product expansions of our businesses may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) which vary by jurisdiction. We currently operate outside of the United States and in the future may acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our UnitedHealthcare Global business subjects us to Brazilian laws and regulations affecting hospitals, managed care and insurance industries and to regulation by Brazilian regulators, including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, while our Banmédica business is subject to Chilean, Colombian and Peruvian laws, regulations and regulators applicable to hospitals and private insurance. Any international regulator may take an approach to the interpretation, implementation and enforcement of industry regulations which could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws regulating the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted operating margins which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations which could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive substantial revenues from these programs. Certain of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or termination of the contract at the option of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes which may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state

governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example, CMS has in the past reduced or frozen Medicare Advantage benchmarks, and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit. States have also made changes in rates and reimbursements for Medicaid members and audits can result in unexpected recoupments.

Under the Medicaid managed care program, state Medicaid agencies seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members who were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs and other factors. If any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, implementation of material program or policy changes after our bid submission, or submission by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of the ACA, CMS has a system providing various quality bonus payments to Medicare Advantage plans meeting certain quality star ratings at the individual plan or local contract level. The star rating system considers various measures adopted by CMS, including, among others, quality of care, preventive services, chronic illness management, handling of appeals and customer satisfaction. Plans must have a rating of four stars or higher to qualify for bonus payments. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial position and cash flows. Any changes in standards or care delivery models applying to government health care programs, including Medicare and Medicaid, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjustment of monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers for Medicare Advantage plans, as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs forecasted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Certain of our local plans have been selected for such audits, which in the past have resulted and in the future could result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS.

We have been and in the future may become involved in routine, regular and special governmental investigations, audits, reviews and assessments. Such investigations, audits, reviews or assessments sometimes arise out of, or prompt claims by

private litigants or whistleblowers who, among other allegations, may claim we failed to disclose certain business practices or, as a government contractor, submitted false or erroneous claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which have resulted in, and in the future could result in, adverse publicity, the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

Our businesses providing pharmacy care services face regulatory and operational risks and uncertainties which may differ from the risks of our other businesses.

We provide pharmacy care services through our Optum Rx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback, beneficiary inducement and other laws governing the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. In addition, federal and state legislatures regularly consider new regulations for the industry which could materially affect current industry practices, including potential new legislation and regulations regarding the receipt or disclosure of rebates and other fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies. Additionally, various governmental agencies have conducted investigations into certain PBM practices, which have resulted in other PBMs agreeing to civil penalties, including the payment of money and entry into corporate integrity agreements. As a provider of pharmacy benefit management services, Optum Rx is also subject to an increasing number of licensure, registration and other laws and accreditation standards. Optum Rx also conducts business through home delivery, specialty and compounding pharmacies, pharmacies located in community mental health centers and home infusion, which subjects it to extensive federal, state and local laws and regulations, including those of the DEA and individual state controlled substance authorities, the Food and Drug Administration (FDA) and Boards of Pharmacy.

We could face potential claims in connection with purported errors by our home delivery, specialty or compounding or clinic-based pharmacies or the provision of home infusion services, including as a result of the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions from any of our home delivery, specialty pharmacy or home infusion services could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our pharmacy care services businesses provide services to sponsors of health benefit plans subject to ERISA. A private party or the DOL, which is the agency that enforces ERISA, could assert the fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy care services businesses even where those businesses are not contractually obligated to assume fiduciary obligations. If a court were to determine fiduciary obligations apply, we could be subject to claims for breaches of fiduciary obligations or claims we entered into certain prohibited transactions.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, including with respect to third-party service providers utilizing protected personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of protected personal information are regulated at the federal, state, international and industry levels and addressed in requirements imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations.

Internationally, many of the jurisdictions in which we operate have established their own data security and privacy legal framework with which we or our customers must comply. We expect there will continue to be new proposed laws, regulations and industry standards concerning privacy, data protection and information security in the European Union, Brazil, Chile, India and other jurisdictions, and we cannot yet determine the impacts such future laws, regulations and standards may have on our businesses or the businesses of our customers. For example, effective May 2018, the European Union's General Data Protection Regulation (GDPR) overhauled data protection laws in the European Union. GDPR has imposed more stringent European Union

data protection requirements on us or our customers, and prescribed greater penalties for noncompliance. Brazilian privacy legislation, similar in certain respects to GDPR, took effect in September 2020.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard designed to protect payment card account data.

HIPAA requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain protected personal information in order to provide services to these customers. HHS administers its audit program to assess HIPAA compliance efforts by covered entities and business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, we maintain a database of administrative and clinical data statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of protected personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business and, among other consequences, could subject us to mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents, and material fines, penalties and litigation awards. Any of these consequences could have a material and adverse effect on our results of operations, financial position and cash flows.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our results of operations, financial position and cash flows.

Because we operate as a holding company, we are dependent on dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by state departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily on the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries exceeding specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flows could be materially and adversely affected.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions "Legal Matters" and "Governmental Investigations, Audits and Reviews" in Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data"

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2022, there were 10,644 registered holders of record of our common stock.

DIVIDEND POLICY

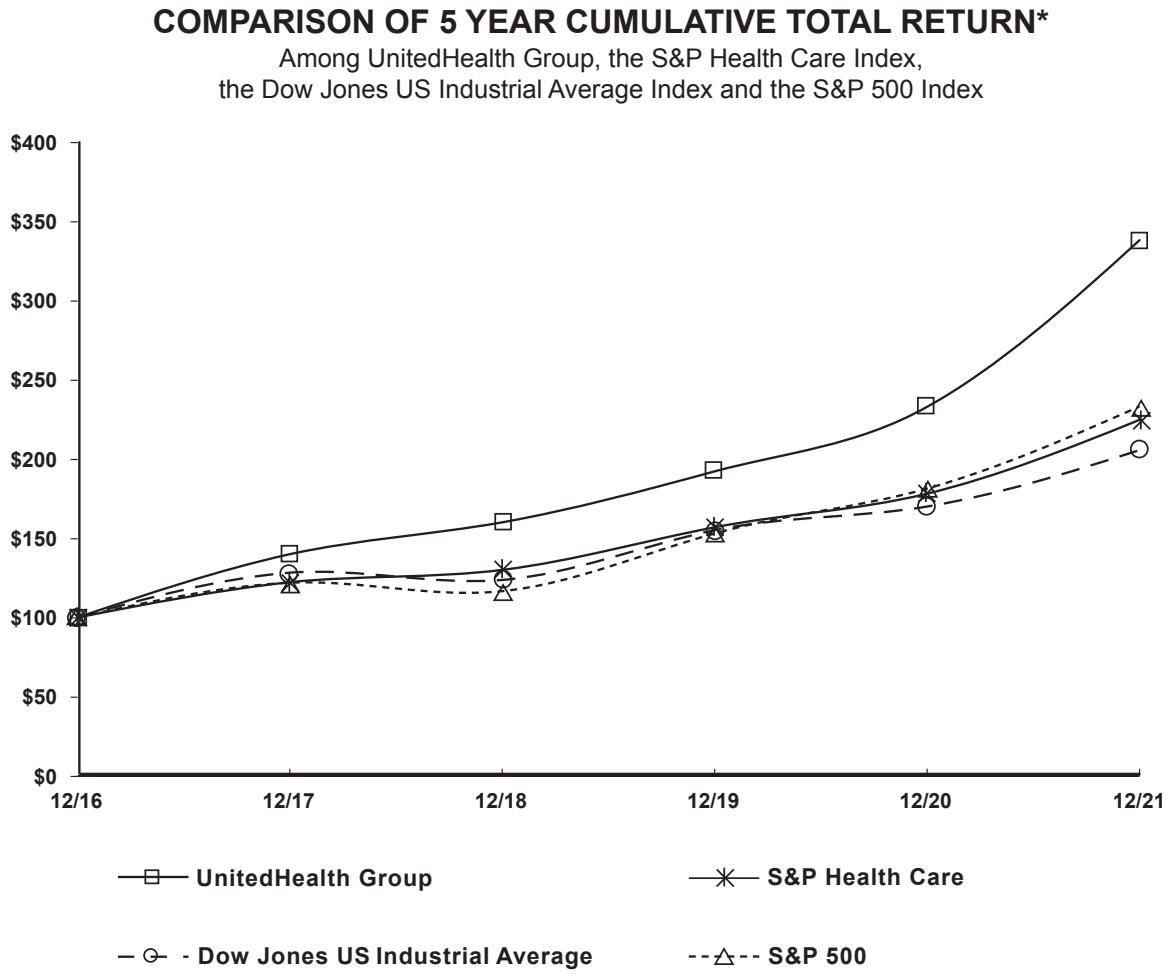
In June 2021, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of $5.80 compared to $5.00 per share, which the Company had paid since June 2020. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During the fourth quarter of 2021, we repurchased 2.3 million shares at an average price of $447.99 per share. As of December 31, 2021, we had Board authorization to purchase up to 45 million shares of our common stock.

PERFORMANCE GRAPH

The following performance graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P Health Care Index, the Dow Jones US Industrial Average Index and the S&P 500 index for the five-year period ended December 31, 2021. The comparisons assume the investment of $100 on December 31, 2016 in our common stock and in each index, and dividends were reinvested when paid.



	12/16	12/17	12/18	12/19	12/20	12/21
UnitedHealth Group	**$100.00**	**$139.82**	**$160.13**	**$192.13**	**$232.87**	**$338.16**
S&P Health Care Index	**100.00**	**122.08**	**129.97**	**157.04**	**178.15**	**224.70**
Dow Jones US Industrial Average	**100.00**	**128.11**	**123.65**	**154.99**	**170.06**	**205.68**
S&P 500 Index	**100.00**	**121.83**	**116.49**	**153.17**	**181.35**	**233.41**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. [Reserved]

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Part II Item 8, "Financial Statements and Supplementary Data." Readers are cautioned the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties which may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

Discussions of year-over-year comparisons between 2020 and 2019 are not included in this Form 10-K and can be found in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" of the Company's Form 10-K for the fiscal year ended December 31, 2020.

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health care company with a mission to help people live healthier lives and help make the health system work better for everyone. Our two complementary businesses—Optum and UnitedHealthcare—are driven by this unified mission and vision to improve health care access, affordability, experiences and outcomes for the individuals and organizations we are privileged to serve.

We have four reportable segments across our two business platforms, Optum and UnitedHealthcare:

- Optum Health;
- Optum Insight;
- Optum Rx; and
- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 13 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Business Trends

Our businesses participate in the United States, South America and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises 18% of gross domestic product (GDP). We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macroeconomic conditions, such as the economic impact of COVID-19, and regulatory changes, which could impact our results of operations, including our continued efforts to control health care costs.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs, including any potential impacts from COVID-19. We frequently evaluate and adjust our approach in each of the local markets we serve, considering relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum MLR thresholds. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in the small group, large group and individual segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs.

Medicare Advantage funding continues to be pressured, as discussed below in "Regulatory Trends and Uncertainties."

We expect Medicaid revenue growth due to anticipated changes in mix and pricing trends; we also believe the payment rate environment creates the risk of continued downward pressure on Medicaid margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We continue to advocate for actuarially sound rates commensurate with our medical cost trends and we remain dedicated to partnering with those states that are committed to the long-term viability of their programs.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. COVID-19 related care costs as well as the deferral of care have impacted medical cost trends in 2021 and may continue to do so in 2022 and subsequent years. Future medical cost trends may be impacted by increased consumer demand for care, potentially even higher acuity care, due to the temporary deferral of care since the onset of the pandemic. We endeavor to mitigate those increases by engaging physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high-quality, affordable care. The continued uncertain impact of COVID-19 may impact our ability to estimate medical costs payable, which has resulted in, and could continue to result in, increased variability to medical cost reserve development.

Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality, improve the health of populations and reduce costs. We continue to see a greater number of people enrolled in plans with underlying performance-based care provider payment models rewarding high-quality, affordable care and foster collaboration. We work together with clinicians to leverage our data and analytics to provide the necessary information to close gaps in care and improve overall health outcomes for patients.

This trend is creating needs for health management services which can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe provide growth opportunities for our Optum business platform.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to regulatory matters. For additional information regarding regulatory trends and uncertainties, see Part I, Item 1 "Business—Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates. Final 2022 Medicare Advantage rates resulted in an increase in industry base rates of approximately 4.1%, short of the industry forward medical cost trend, creating continued pressure in the Medicare Advantage program.

The ongoing Medicare Advantage funding pressure places continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we have made to partially offset these rate pressures and reductions. In some years, these adjustments impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits and implement or increase the member premiums supplementing the monthly payments we receive from the government. Additionally, we decide annually on a county-by-county basis where we will offer Medicare Advantage plans.

Our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on our local plans' Star ratings. The level of Star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses.

ACA Tax (Health Insurance Tax). The Health Insurance Tax was permanently repealed by Congress, effective January 1, 2021. The permanent repeal of the tax impacts year-over-year comparability of our financial statements, including revenues, operating costs, medical care ratio (MCR), operating cost ratio, effective tax rate and cash flows from operations.

COVID-19 Trends and Uncertainties

The COVID-19 pandemic continues to evolve and the ultimate impact on our business, results of operations, financial condition and cash flows remains uncertain. In 2021, overall care activity continued to increase, including a mix of temporary deferral of care activity and COVID-19 related care costs. The temporary deferral of care was more than offset by COVID-19 related care and testing costs, rebate requirements and other revenue impacts and general economic impacts. In future periods, care patterns may moderately exceed normal baselines as previously deferred care is obtained and acuity temporarily rises due to missed regular care. From time to time, health system capacity may be subject to possible increased volatility due to the pandemic. Specific trends and uncertainties related to our two business platforms are as follows:

Optum. COVID-19 related care costs continued to impact our Optum Health value-based care delivery businesses, which were partially offset by the continued temporary deferral of care. The temporary deferral of care reduced fee-for-service care delivery volume, as well as Optum Insight and Optum Rx volume-based business activity, although we expect the impact to continue decreasing as care returns to, and potentially exceeds, normal levels. We believe COVID-19 will continue to influence customer and consumer behavior, both during and after the pandemic, which could impact how and where care is delivered and the manner in which consumers wish to receive their prescription drugs or infusion services. As a result of the dynamic situation and broad-reaching impact to the health system, the ultimate impact of COVID-19 on our Optum businesses is uncertain.

UnitedHealthcare. In 2021, we continued expanded benefit coverage in areas such as COVID-19 related care and testing, telemedicine, and pharmacy; we also continued to assist our customers, care providers, members and communities in addressing the COVID-19 crisis. UnitedHealthcare's 2021 results of operations were negatively impacted by COVID-19 related care and testing, rebate requirements and other revenue impacts, as well as broader economic impacts, partially offset by the continued deferral of care. The increase in people served through Medicaid was attributable in part to continuing action by states to ease eligibility redetermination requirements due to the COVID-19 public health emergency.

Disrupted care patterns, as a result of the pandemic, have affected and may continue to temporarily affect the ability to obtain complete member health status information, impacting revenue in businesses utilizing risk adjustment methodologies. The ultimate overall impact is uncertain and dependent on the future pacing, intensity and duration of the pandemic, the severity of new variants of the COVID-19 virus, the effectiveness and extent of administration of vaccination and treatments and general economic uncertainty.

SELECTED OPERATING PERFORMANCE ITEMS

The following represents a summary of select 2021 year-over-year operating comparisons to 2020.

- Consolidated revenues increased by 12%, UnitedHealthcare revenues increased 11% and Optum revenues grew 14%.
- UnitedHealthcare served 2.1 million more people domestically, primarily driven by growth in community and senior programs.
- Earnings from operations increased by 7%, including an increase of 19% at Optum, partially offset by a decrease of 3% at UnitedHealthcare.
- Diluted earnings per common share increased 13% to $18.08.
- Cash flows from operations were $22.3 billion.
- Return on equity was 25.2%.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31, 2021	2020	2019	Change 2021 vs. 2020	
Revenues:					
Premiums	$226,233	$201,478	$189,699	$24,755	12%
Products	34,437	34,145	31,597	292	1
Services	24,603	20,016	18,973	4,587	23
Investment and other income	2,324	1,502	1,886	822	55
Total revenues	287,597	257,141	242,155	30,456	12
Operating costs:					
Medical costs	186,911	159,396	156,440	27,515	17
Operating costs	42,579	41,704	35,193	875	2
Cost of products sold	31,034	30,745	28,117	289	1
Depreciation and amortization	3,103	2,891	2,720	212	7
Total operating costs	263,627	234,736	222,470	28,891	12
Earnings from operations	23,970	22,405	19,685	1,565	7
Interest expense	(1,660)	(1,663)	(1,704)	3	—
Earnings before income taxes	22,310	20,742	17,981	1,568	8
Provision for income taxes	(4,578)	(4,973)	(3,742)	395	(8)
Net earnings	17,732	15,769	14,239	1,963	12
Earnings attributable to noncontrolling interests	(447)	(366)	(400)	(81)	22
Net earnings attributable to UnitedHealth Group common shareholders	$ 17,285	$ 15,403	$ 13,839	$ 1,882	12%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 18.08	$ 16.03	$ 14.33	$ 2.05	13%
Medical care ratio (a)	82.6%	79.1%	82.5%	3.5%	
Operating cost ratio	14.8	16.2	14.5	(1.4)	
Operating margin	8.3	8.7	8.1	(0.4)	
Tax rate	20.5	24.0	20.8	(3.5)	
Net earnings margin (b)	6.0	6.0	5.7	—	
Return on equity (c)	25.2%	24.9%	25.7%	0.3%	

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Net earnings margin attributable to UnitedHealth Group shareholders.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

2021 RESULTS OF OPERATIONS COMPARED TO 2020 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues were primarily driven by the increase in the number of individuals served through Medicare Advantage, Medicaid and commercial offerings; pricing trends; and organic and acquisition growth across the Optum business, primarily due to expansion in care delivery.

Medical Costs and MCR

Medical costs increased as a result of growth in people served through Medicare Advantage, Medicaid and commercial offerings, as well as increased COVID-19 related care costs and medical cost trends, partially offset by higher temporary care deferrals. The MCR increased due to increased COVID-19 related care costs and the permanent repeal of the Health Insurance Tax, partially offset by increased temporary care deferrals. Medical costs and the MCR were also impacted by increased prior year favorable reserve development.

Operating Cost Ratio

The operating cost ratio decreased primarily due to the permanent repeal of the Health Insurance Tax, COVID-19 impacts on revenue and operating costs in the prior year and operating efficiency gains, partially offset by business mix.

Income Tax Rate

Our effective tax rate decreased primarily due to the permanent repeal of the nondeductible Health Insurance Tax.

Reportable Segments

See Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data ” for more information on our segments. We utilize various metrics to evaluate and manage our reportable segments, including individuals served by UnitedHealthcare by major market segment and funding arrangement, people served by Optum Health and adjusted scripts for Optum Rx. These metrics are the main drivers of revenue, earnings and cash flows at each business. The metrics also allow management and investors to evaluate and understand business mix, including the mix of care delivered through accountable care models at Optum Health, customer penetration and pricing trends when comparing the metrics to revenue by segment.

The following table presents a summary of the reportable segment financial information:

	For the Years Ended December 31,			Change	
(in millions, except percentages)	**2021**	**2020**	**2019**	**2021 vs. 2020**	
Revenues					
UnitedHealthcare	$222,899	$200,875	$193,842	$ 22,024	11%
Optum Health	54,065	39,808	30,317	14,257	36
Optum Insight	12,199	10,802	10,006	1,397	13
Optum Rx	91,314	87,498	74,288	3,816	4
Optum eliminations	(2,013)	(1,800)	(1,661)	(213)	12
Optum	155,565	136,308	112,950	19,257	14
Eliminations	(90,867)	(80,042)	(64,637)	(10,825)	14
Consolidated revenues	$287,597	$257,141	$242,155	$ 30,456	12%
Earnings from operations					
UnitedHealthcare	$ 11,975	$ 12,359	$ 10,326	$ (384)	(3)%
Optum Health	4,462	3,434	2,963	1,028	30
Optum Insight	3,398	2,725	2,494	673	25
Optum Rx	4,135	3,887	3,902	248	6
Optum	11,995	10,046	9,359	1,949	19
Consolidated earnings from operations	$ 23,970	$ 22,405	$ 19,685	$ 1,565	7%
Operating margin					
UnitedHealthcare	5.4%	6.2%	5.3%	(0.8)%	
Optum Health	8.3	8.6	9.8	(0.3)	
Optum Insight	27.9	25.2	24.9	2.7	
Optum Rx	4.5	4.4	5.3	0.1	
Optum	7.7	7.4	8.3	0.3	
Consolidated operating margin	8.3%	8.7%	8.1%	(0.4)%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	For the Years Ended December 31, 2021	2020	2019	Change 2021 vs. 2020	
UnitedHealthcare Employer & Individual	$ 60,023	$ 55,872	$ 56,945	$ 4,151	7%
UnitedHealthcare Medicare & Retirement	100,552	90,764	83,252	9,788	11
UnitedHealthcare Community & State	53,979	46,487	43,790	7,492	16
UnitedHealthcare Global	8,345	7,752	9,855	593	8
Total UnitedHealthcare revenues	$222,899	$200,875	$193,842	$22,024	11%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31, 2021	2020	2019	Change 2021 vs. 2020	
Commercial:					
Risk-based	7,985	7,910	8,575	75	1%
Fee-based	18,595	18,310	19,185	285	2
Total commercial	26,580	26,220	27,760	360	1
Medicare Advantage	6,490	5,710	5,270	780	14
Medicaid	7,655	6,620	5,900	1,035	16
Medicare Supplement (Standardized)	4,395	4,460	4,500	(65)	(1)
Total community and senior	18,540	16,790	15,670	1,750	10
Total UnitedHealthcare—domestic medical	45,120	43,010	43,430	2,110	5
Global	5,510	5,425	5,720	85	2
Total UnitedHealthcare—medical	50,630	48,435	49,150	2,195	5%
Supplemental Data:					
Medicare Part D stand-alone	3,700	4,045	4,405	(345)	(9)%

Commercial business increased primarily due to acquisitions in risk-based and fee-based offerings and organic growth in innovative products. Medicare Advantage increased due to growth in people served through individual and group Medicare Advantage plans. The increase in people served through Medicaid was primarily driven by states continuing to ease redetermination requirements due to COVID-19, new state-based awards and growth in people served through Dual Special Needs Plans.

UnitedHealthcare's revenues increased due to growth in the number of individuals served through Medicare Advantage and Medicaid, including a greater mix of people with higher acuity needs, and an increase in the number of individuals served through commercial benefits, partially offset by the permanent repeal of the Health Insurance Tax and the impacts of COVID-19 on risk adjusted business. Earnings from operations decreased due to increased COVID-19 related care costs and the impacts of COVID-19 on risk adjusted business, partially offset by higher temporary deferral of care and growth in people served across our domestic businesses.

Optum

Total revenues and earnings from operations increased due to growth across the Optum businesses. The results by segment were as follows:

Optum Health

Revenues at Optum Health increased primarily due to organic growth in value-based arrangements, acquisitions in care delivery and the impact of COVID-19 at our fee-based businesses as consumers resumed elective care. Earnings from operations increased due to the factors impacting revenues as well as cost management initiatives and increased investment income. COVID-19 related care costs and temporary care deferrals affected earnings from operations at our value-based and fee-based businesses in offsetting manners. Optum Health served approximately 100 million people as of December 31, 2021 compared to 98 million people as of December 31, 2020.

Optum Insight

Revenues and earnings from operations at Optum Insight increased due to growth in technology and managed services, including expanding relationships serving health systems. Earnings from operations also increased due to productivity gains and cost management initiatives.

Optum Rx

Revenues and earnings from operations at Optum Rx increased due to higher script volumes from growth in people served, increased utilization and organic growth in pharmacy care services. Earnings from operations also increased as a result of continued supply chain and cost management initiatives. Optum Rx fulfilled 1.4 billion and 1.3 billion adjusted scripts in 2021 and 2020, respectively. In addition to the factors contributing to revenue growth, adjusted scripts also increased due to the dispensing of COVID-19 vaccines.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to, among other things, minimum levels of statutory capital, as defined by their respective jurisdictions, and restrictions on the timing and amount of dividends paid to their parent companies.

Our U.S. regulated subsidiaries paid their parent companies dividends of $8.0 billion and $8.3 billion in 2021 and 2020, respectively. See Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for further detail concerning our regulated subsidiary dividends.

Our nonregulated businesses also generate significant cash flows from operations available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt and return capital to our shareholders through dividends and repurchases of our common stock.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	For the Years Ended December 31, 2021	2020	2019	Change 2021 vs. 2020
Sources of cash:				
Cash provided by operating activities	$ 22,343	$ 22,174	$ 18,463	$ 169
Issuances of long-term debt and short-term borrowings, net of repayments	2,481	2,586	3,994	(105)
Proceeds from common share issuances	1,355	1,440	1,037	(85)
Customer funds administered	622	1,677	13	(1,055)
Other	—	—	219	—
Total sources of cash	26,801	27,877	23,726	
Uses of cash:				
Cash paid for acquisitions, net of cash assumed	(4,821)	(7,139)	(8,343)	2,318
Cash dividends paid	(5,280)	(4,584)	(3,932)	(696)
Common share repurchases	(5,000)	(4,250)	(5,500)	(750)
Purchases of property, equipment and capitalized software	(2,454)	(2,051)	(2,071)	(403)
Purchases of investments, net of sales and maturities	(1,843)	(2,836)	(2,504)	993
Purchases of redeemable noncontrolling interests	(1,338)	—	(618)	(1,338)
Other	(1,549)	(965)	(619)	(584)
Total uses of cash	(22,285)	(21,825)	(23,587)	
Effect of exchange rate changes on cash and cash equivalents	(62)	(116)	(20)	54
Net increase in cash and cash equivalents	$ 4,454	$ 5,936	$ 119	$ (1,482)

2021 Cash Flows Compared to 2020 Cash Flows

Cash flows provided by operating activities were largely consistent, with higher net earnings being offset by changes in working capital accounts. Other significant changes in sources or uses of cash year-over-year included decreased customer funds administered and increased purchases of redeemable noncontrolling interests, share repurchases and cash dividends paid, partially offset by decreased cash paid for acquisitions and net purchases of investments.

Financial Condition

As of December 31, 2021, our cash, cash equivalent, available-for-sale debt securities and equity securities balances of $65.1 billion included $21.4 billion of cash and cash equivalents (of which $2.8 billion was available for general corporate use), $40.2 billion of debt securities and $3.5 billion of equity securities. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is fully supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 3.9 years and a weighted-average credit rating of “Double A” as of December 31, 2021. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

Cash Requirements. The Company’s cash requirements within the next twelve months include medical costs payable, accounts payable and accrued liabilities, short-term borrowings and current maturities of long-term debt, other current liabilities, and purchase commitments and other obligations. We expect the cash required to meet these obligations to be primarily generated

through cash flows from current operations; cash available for general corporate use; and the realization of current assets, such as accounts receivable.

Our long-term cash requirements under our various contractual obligations and commitments include:

- *Debt Obligations.* See Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail of our long-term debt and the timing of expected future payments. Interest coupon payments are typically paid semi-annually.
- *Operating leases.* See Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail of our obligations and the timing of expected future payments.
- *Purchase and other obligations.* These include $4.7 billion, $2.7 billion of which is expected to be paid within the next twelve months, of fixed or minimum commitments under existing purchase obligations for goods and services, including agreements cancelable with the payment of an early termination penalty, and remaining capital commitments for venture capital funds and other funding commitments. These amounts exclude agreements cancelable without penalty and liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2021.
- *Other Liabilities.* These include other long-term liabilities reflected in our Consolidated Balance Sheets as of December 31, 2021, including obligations associated with certain employee benefit programs, unrecognized tax benefits and various long-term liabilities, which have some inherent uncertainty in the timing of these payments.
- *Redeemable noncontrolling interests.* See Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail. We do not have any material required redemptions in the next twelve months.

We expect the cash required to meet our long-term obligations to be primarily generated through future cash flows from operations. However, we also have the ability to generate cash to satisfy both our current and long-term requirements through the issuance of commercial paper, issuance of long-term debt, or drawing under our committed credit facilities or the ability to sell investments. We believe our capital resources are sufficient to meet future, short-term and long-term, liquidity needs.

Short-Term Borrowings. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of senior unsecured debt through independent broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 60%, subject to increase in certain circumstances set forth in the applicable credit agreement. As of December 31, 2021, our debt to debt-plus-shareholders' equity ratio, as defined and calculated under the credit facilities, was 36%.

Long-Term Debt. Periodically, we access capital markets to issue long-term debt for general corporate purposes, such as, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases. For more information on our debt, see Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8 "Financial Statements and Supplementary Data."

Credit Ratings. Our credit ratings as of December 31, 2021 were as follows:

	Moody's		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A+	Stable	A	Stable	A	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-1+	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic

and market conditions. A significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. As of December 31, 2021, we had Board authorization to purchase up to 45 million shares of our common stock. For more information on our share repurchase program, see Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements.and Supplementary Data."

Dividends. In June 2021, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of $5.80 compared to $5.00 per share, which the Company had paid since June 2020. For more information on our dividend, see Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements.and Supplementary Data."

Pending Acquisitions. In 2021, we entered into agreements to acquire multiple companies in the health care sector, most notably, Change Healthcare (NASDAQ: CHNG), subject to regulatory approval and other customary closing conditions. Additionally, in January 2022, we entered into agreements to acquire multiple companies in the health care sector, subject to regulatory approval and other customary closing conditions. The total anticipated capital required for these acquisitions, excluding the payoff of acquired indebtedness, is approximately $12 billion.

We do not have other significant contractual obligations or commitments requiring cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications and may include acquisitions.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates requiring management to make challenging, subjective or complex judgments, often because they must estimate the effects of matters inherently uncertain and may change in subsequent periods. Critical accounting estimates involve judgments and uncertainties which are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

Medical costs and medical costs payable include estimates of our obligations for medical care services rendered on behalf of consumers, but for which claims have either not yet been received or processed. Depending on the health care professional and type of service, the typical billing lag for services can be up to 90 days from the date of service. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months. As of December 31, 2021, our days outstanding in medical payables was 47 days, calculated as total medical payables divided by total medical costs times the number of days in the period.

In each reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods. If the revised estimate of prior period medical costs is less than the previous estimate, we will decrease reported medical costs in the current period (favorable development). If the revised estimate of prior period medical costs is more than the previous estimate, we will increase reported medical costs in the current period (unfavorable development). Medical costs in 2021, 2020 and 2019 included favorable medical cost development related to prior years of $1.7 billion, $880 million and $580 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, for the most recent two months, we estimate claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period adjudicated by us at the date of estimation. Completion

factors are the most significant factors we use in developing our medical costs payable estimates for periods prior to the most recent two months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim levels and processing cycles, as well as other factors. Our judgments also consider the impacts of COVID-19 on these factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserve estimates may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2021:

Completion Factors (Decrease) Increase in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 686
(0.50)	456
(0.25)	228
0.25	(226)
0.50	(452)
0.75	(676)

Medical Cost Per Member Per Month Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent two months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design and a review of a broad set of health care utilization indicators, which included consideration of COVID-19. These factors include but are not limited to pharmacy utilization trends, inpatient hospital authorization data and influenza incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as GDP growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates, including: our ability and practices to manage medical and pharmaceutical costs, changes in level and mix of services utilized; mix of benefits offered, including the impact of co-pays and deductibles; changes in medical practices; and catastrophes, epidemics and pandemics, such as COVID-19.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent two months as of December 31, 2021:

Medical Cost PMPM Quarterly Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 895
2	597
1	298
(1)	(298)
(2)	(597)
(3)	(895)

The completion factors and medical costs PMPM trend factors analyses above include outcomes considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2021; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2021 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2021 net earnings would have increased or decreased by approximately $184 million.

For more detail related to our medical cost estimates, see Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.”

Goodwill

We evaluate goodwill for impairment annually or more frequently when an event occurs or circumstances change indicating the carrying value may not be recoverable. When testing goodwill for impairment, we may first assess qualitative factors to determine if it is more likely than not the carrying value of a reporting unit exceeds its estimated fair value. During a qualitative analysis, we consider the impact of changes, if any, to the following factors: macroeconomic, industry and market factors; cost factors; changes in overall financial performance; and any other relevant events and uncertainties impacting a reporting unit. If our qualitative assessment indicates a goodwill impairment is more likely than not, we perform additional quantitative analyses. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing. For reporting units where a quantitative analysis is performed, we perform a test measuring the fair values of the reporting units and comparing them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, an impairment is recognized for the difference, up to the carrying amount of goodwill.

We estimate the fair values of our reporting units using a discounted cash flow method or a weighted combination of discounted cash flows and a market-based method. The discounted cash flow method includes assumptions about a wide variety of internal and external factors. Significant assumptions used in the discounted cash flow method include financial projections of free cash flow, including revenue trends, medical costs trends, operating productivity, income taxes and capital levels; long-term growth rates for determining terminal value beyond the discretely forecasted periods; and discount rates. Financial projections and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. Our most significant estimate in the discount rate determinations involves our adjustments to the peer company weighted average costs of capital reflecting reporting unit-specific factors. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty. The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units’ operations could cause these assumptions to change in the future. Additionally, as part of our quantitative impairment testing, we perform various sensitivity analyses on certain key assumptions, such as discount rates, cash flow projections and peer company multiples to analyze the potential for a material impact. The market-based method requires determination of an appropriate peer group whose securities are traded on an active market. The peer group is used to derive market multiples to estimate fair value. As of October 1, 2021, we completed our annual impairment tests for goodwill with all of our reporting units having fair values substantially in excess of their carrying values.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.”

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our Board of Directors. This policy limits the amounts which may be invested in any one issuer and generally limits our investments to U.S. government and agency securities, state and municipal securities and corporate debt obligations of investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups and other customers constituting our client base. As of December 31, 2021, there were no significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to changes in interest rates impacting our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, as well as foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real and Chilean peso.

As of December 31, 2021, we had $25 billion of financial assets on which the interest rates received vary with market interest rates, which may significantly impact our investment income. Also as of December 31, 2021, $7 billion of our financial liabilities, which include debt and deposit liabilities, were at interest rates which vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2021, $37 billion of our investments were fixed-rate debt securities and $45 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed-income market sectors and debt across maturities, as well as by matching a portion of our floating-rate assets and liabilities, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale debt securities are reported in comprehensive income.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of December 31, 2021 and 2020 on our investment income and interest expense per annum and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2021			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets	Fair Value of Financial Liabilities
2%	$ 499	$ 133	$ (3,080)	$ (8,664)
1	250	67	(1,564)	(4,723)
(1)	(85)	(7)	1,398	5,655
(2)	(85)	(7)	1,857	10,892

	December 31, 2020			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets	Fair Value of Financial Liabilities
2%	$ 401	$ 163	$ (3,020)	$ (8,700)
1	201	82	(1,499)	(4,744)
(1)	(75)	(12)	820	5,266
(2)	(75)	(12)	886	8,101

Note: Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2021 and 2020, the assumed hypothetical change in interest rates does not reflect the full 100 and 200 basis point reduction in interest income or interest expense, as the rates are assumed not to fall below zero. As of December 31, 2021 and 2020, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

We have an exposure to changes in the value of foreign currencies, primarily the Brazilian real and the Chilean peso, to the U.S. dollar in translation of UnitedHealthcare Global's operating results at the average exchange rate over the accounting period, and UnitedHealthcare Global's assets and liabilities at the exchange rate at the end of the accounting period. The gains or losses resulting from translating foreign assets and liabilities into U.S. dollars are included in equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real or Chilean peso reduces the carrying value of the net assets denominated in those currencies. For example, as of December 31, 2021, a hypothetical 10% and 25% increase in the value of the U.S. dollar against those currencies would have caused a reduction in net assets of approximately $520 million and $1.1 billion, respectively. We manage exposure to foreign currency earnings risk primarily by conducting our international business operations in their functional currencies.

As of December 31, 2021, we had $3.5 billion of investments in equity securities, primarily consisting of investments in employee savings plan related investments, other venture investments and non-U.S. dollar fixed-income funds. Valuations in non-U.S. dollar funds are subject to foreign exchange rates.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2021 and 2020, the related consolidated statements of operations, comprehensive income, changes in equity and cash flows for each of the three years in the period ended December 31, 2021, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2021 and 2020, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2021, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2021, based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 15, 2022 expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current-period audit of the financial statements that were communicated or required to be communicated to the audit and finance committee and that (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Incurred but not Reported (IBNR) Claim Liability - Refer to Notes 2 and 7 to the financial statements.

Critical Audit Matter Description

Medical costs payable includes estimates of the Company's obligations for medical care services rendered on behalf of insured consumers, for which claims have either not yet been received or processed. These estimates are referred to as incurred but not reported (IBNR) claim liabilities. At December 31, 2021 the Company's IBNR balance was $17 billion. The Company develops IBNR estimates using an actuarial model that requires management to exercise certain judgments in developing its estimates. Judgments made by management include medical cost per member per month trend factors and completion factors, which

include assumptions over the time from date of service to claim receipt, the impact of claim levels, processing cycles, and consideration of COVID-19.

We identified the IBNR claim liability as a critical audit matter because of the significant assumptions made by management in estimating the liability. This required complex auditor judgment, and an increased extent of effort, including the involvement of actuarial specialists in performing procedures to evaluate the reasonableness of management's methods, assumptions and judgments in developing the liability.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures included the following, among others:

- We tested the effectiveness of controls over management's estimate of the IBNR claim liability balance, including controls over the judgments in both the completion factors and the medical cost per member per month trend factors, as well as controls over the claims and membership data used in the estimation process.
- We tested the underlying claims and membership data and other information that served as the basis for the actuarial analysis, to test that the inputs to the actuarial estimate were complete and accurate.
- With the assistance of actuarial specialists, we evaluated the reasonableness of the actuarial methods and assumptions used by management to estimate the IBNR claim liability by:
    - Performing an overlay of the historical claims data used in management's current year model to the data used in prior periods to validate that there were no material changes to the claims data tested in prior periods.
    - Developing an independent estimate of the IBNR claim liability and comparing our estimate to management's estimate.
    - Performing a retrospective review comparing management's prior year estimate of IBNR to claims processed in 2021 with dates of service in 2020 or prior.

Goodwill - Refer to Notes 2 and 6 to the financial statements.

Critical Audit Matter Description

At December 31, 2021, the Company's goodwill balance was $76 billion. As discussed in Note 2 of the financial statements, for reporting units where a quantitative analysis is performed, the Company performs an annual impairment test measuring the fair values of the reporting units and comparing them to their aggregate carrying values including goodwill. The estimates of the reporting unit fair values are calculated using a discounted cash flow method or a weighted combination of discounted cash flows and a market-based method. The discounted cash flow method includes assumptions about revenue trends, medical cost trends, and operating costs as well as discount rates. The market-based method requires determination of an appropriate group of peer companies whose securities are traded on an active market. The annual impairment test indicated that the fair values of the reporting units exceeded the carrying values as of the impairment testing date; therefore, no impairment was recognized.

We identified a critical audit matter related to the quantitative analysis performed for such reporting units because of the significant assumptions made by management to estimate the fair value of the reporting unit. This required increased auditor judgment and extent of effort, including involvement of fair value specialists to evaluate the reasonableness of management's estimates and assumptions related to peer company selection and financial projections, which can be impacted by regulatory and macro-economic factors.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures related to the valuation, business, and market assumptions including the discount rate, financial forecasts, and peer group used by management to estimate the fair value of reporting units where a quantitative analysis was performed, included the following, among others:

- We tested the effectiveness of controls over management's annual goodwill impairment assessment, including those over the determination of the fair value such as controls related to management's financial forecasts, as well as controls over the selection of discount rates, company specific risks, peer companies, and market multiples.
- We evaluated management's ability to forecast and meet future revenue, medical cost trend, and operating costs by comparing:
    - Actual results to historical forecasts.
    - Forecasted information to: internal communications to management and the Board of Directors, industry and economic trends, and analyst reports of revenue and earnings expectations for the Company and its peers.
- We evaluated the impact of changes in management's forecasts from the October 1, 2021 annual measurement date to December 31, 2021.
- We evaluated management's selection of peer companies and market multiples.
- With the assistance of our fair value specialists, we evaluated the reasonableness of (1) the valuation methodologies, including testing the mathematical accuracy of the calculation, (2) the weighting of such valuation methodologies, and (3) discount rate and company specific risks by:
    - Testing the source information underlying the determination of the discount rate and the mathematical accuracy of the calculation.
    - Developing a range of independent discount rate estimates and comparing to those selected by management.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 15, 2022

We have served as the Company's auditor since 2002.

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2021	December 31, 2020
Assets		
Current assets:		
Cash and cash equivalents	$ 21,375	$ 16,921
Short-term investments	2,532	2,860
Accounts receivable, net of allowances of $954 and $990	14,216	12,870
Other current receivables, net of allowances of $993 and $1,047	13,866	12,534
Assets under management	4,449	4,076
Prepaid expenses and other current assets	5,320	4,457
Total current assets	61,758	53,718
Long-term investments	43,114	41,242
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $5,992 and $5,230	8,969	8,626
Goodwill	75,795	71,337
Other intangible assets, net of accumulated amortization of $5,636 and $5,455	10,044	10,856
Other assets	12,526	11,510
Total assets	$ 212,206	$ 197,289
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	$ 24,483	$ 21,872
Accounts payable and accrued liabilities	24,643	22,495
Short-term borrowings and current maturities of long-term debt	3,620	4,819
Unearned revenues	2,571	2,842
Other current liabilities	22,975	20,392
Total current liabilities	78,292	72,420
Long-term debt, less current maturities	42,383	38,648
Deferred income taxes	3,265	3,367
Other liabilities	11,787	12,315
Total liabilities	135,727	126,750
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	1,434	2,211
Equity:		
Preferred stock, $0.001 par value—10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value—3,000 shares authorized; 941 and 946 issued and outstanding	10	10
Additional paid-in capital	—	—
Retained earnings	77,134	69,295
Accumulated other comprehensive loss	(5,384)	(3,814)
Nonredeemable noncontrolling interests	3,285	2,837
Total equity	75,045	68,328
Total liabilities, redeemable noncontrolling interests and equity	$ 212,206	$ 197,289

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2021	2020	2019
Revenues:			
Premiums	$226,233	$201,478	$189,699
Products	34,437	34,145	31,597
Services	24,603	20,016	18,973
Investment and other income	2,324	1,502	1,886
Total revenues	287,597	257,141	242,155
Operating costs:			
Medical costs	186,911	159,396	156,440
Operating costs	42,579	41,704	35,193
Cost of products sold	31,034	30,745	28,117
Depreciation and amortization	3,103	2,891	2,720
Total operating costs	263,627	234,736	222,470
Earnings from operations	23,970	22,405	19,685
Interest expense	(1,660)	(1,663)	(1,704)
Earnings before income taxes	22,310	20,742	17,981
Provision for income taxes	(4,578)	(4,973)	(3,742)
Net earnings	17,732	15,769	14,239
Earnings attributable to noncontrolling interests	(447)	(366)	(400)
Net earnings attributable to UnitedHealth Group common shareholders	$ 17,285	$ 15,403	$ 13,839
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$ 18.33	$ 16.23	$ 14.55
Diluted	$ 18.08	$ 16.03	$ 14.33
Basic weighted-average number of common shares outstanding	943	949	951
Dilutive effect of common share equivalents	13	12	15
Diluted weighted-average number of common shares outstanding	956	961	966
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	1	8	10

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2021	2020	2019
Net earnings	$17,732	$15,769	$14,239
Other comprehensive (loss) income:			
Gross unrealized (losses) gains on investment securities during the period	(1,028)	1,058	1,212
Income tax effect	248	(253)	(279)
Total unrealized (losses) gains, net of tax	(780)	805	933
Gross reclassification adjustment for net realized gains included in net earnings	(173)	(75)	(104)
Income tax effect	40	17	24
Total reclassification adjustment, net of tax	(133)	(58)	(80)
Total foreign currency translation losses	(657)	(983)	(271)
Other comprehensive (loss) income	(1,570)	(236)	582
Comprehensive income	16,162	15,533	14,821
Comprehensive income attributable to noncontrolling interests	(447)	(366)	(400)
Comprehensive income attributable to UnitedHealth Group common shareholders	$15,715	$15,167	$14,421

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income: Net Unrealized (Losses) Gains on Investments	Accumulated Other Comprehensive (Loss) Income: Foreign Currency Translation Losses	Nonredeemable Noncontrolling Interests	Total Equity
Balance at January 1, 2019	960	$ 10	$ —	$ 55,846	$ (264)	$ (3,896)	$ 2,623	$ 54,319
Adjustment to adopt ASU 2016-02				(13)			(5)	(18)
Net earnings				13,839			285	14,124
Other comprehensive income (loss)					853	(271)		582
Issuances of common stock, and related tax effects	10	—	696					696
Share-based compensation			673					673
Common share repurchases	(22)	(1)	(937)	(4,562)				(5,500)
Cash dividends paid on common shares ($4.14 per share)				(3,932)				(3,932)
Redeemable noncontrolling interest fair value and other adjustments			(316)					(316)
Acquisition and other adjustments of nonredeemable noncontrolling interests			(109)				196	87
Distributions to nonredeemable noncontrolling interest							(279)	(279)
Balance at December 31, 2019	948	9	7	61,178	589	(4,167)	2,820	60,436
Adjustment to adopt ASU 2016-13				(28)				(28)
Net earnings				15,403			254	15,657
Other comprehensive income (loss)					747	(983)		(236)
Issuances of common stock, and related tax effects	12	1	1,119					1,120
Share-based compensation			647					647
Common share repurchases	(14)	—	(1,576)	(2,674)				(4,250)
Cash dividends paid on common shares ($4.83 per share)				(4,584)				(4,584)
Redeemable noncontrolling interest fair value and other adjustments			(197)					(197)
Acquisition and other adjustments of nonredeemable noncontrolling interests							40	40
Distributions to nonredeemable noncontrolling interest							(277)	(277)
Balance at December 31, 2020	946	10	—	69,295	1,336	(5,150)	2,837	68,328
Net earnings				17,285			360	17,645
Other comprehensive loss					(913)	(657)		(1,570)
Issuances of common stock, and related tax effects	8	—	1,100					1,100
Share-based compensation			729					729
Common share repurchases	(13)	—	(940)	(4,060)				(5,000)
Cash dividends paid on common shares ($5.60 per share)				(5,280)				(5,280)
Redeemable noncontrolling interests fair value and other adjustments			(889)	(106)				(995)
Acquisition and other adjustments of nonredeemable noncontrolling interests							407	407
Distributions to nonredeemable noncontrolling interests							(319)	(319)
Balance at December 31, 2021	941	$ 10	$ —	$ 77,134	$ 423	$ (5,807)	$ 3,285	$ 75,045

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2021	2020	2019
Operating activities			
Net earnings	$ 17,732	$ 15,769	$ 14,239
Noncash items:			
Depreciation and amortization	3,103	2,891	2,720
Deferred income taxes	130	(8)	230
Share-based compensation	800	679	697
Other, net	(944)	(52)	(106)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(1,000)	(688)	162
Other assets	(1,031)	(2,195)	(1,563)
Medical costs payable	2,701	152	1,221
Accounts payable and other liabilities	1,162	5,348	733
Unearned revenues	(310)	278	130
Cash flows from operating activities	22,343	22,174	18,463
Investing activities			
Purchases of investments	(17,139)	(16,577)	(18,131)
Sales of investments	7,045	6,489	8,536
Maturities of investments	8,251	7,252	7,091
Cash paid for acquisitions, net of cash assumed	(4,821)	(7,139)	(8,343)
Purchases of property, equipment and capitalized software	(2,454)	(2,051)	(2,071)
Other, net	(1,254)	(506)	219
Cash flows used for investing activities	(10,372)	(12,532)	(12,699)
Financing activities			
Common share repurchases	(5,000)	(4,250)	(5,500)
Cash dividends paid	(5,280)	(4,584)	(3,932)
Proceeds from common stock issuances	1,355	1,440	1,037
Repayments of long-term debt	(3,150)	(3,150)	(1,750)
(Repayments of) proceeds from short-term borrowings, net	(1,302)	872	300
Proceeds from issuance of long-term debt	6,933	4,864	5,444
Customer funds administered	622	1,677	13
Purchases of redeemable noncontrolling interests	(1,338)	—	(618)
Other, net	(295)	(459)	(619)
Cash flows used for financing activities	(7,455)	(3,590)	(5,625)
Effect of exchange rate changes on cash and cash equivalents	(62)	(116)	(20)
Increase in cash and cash equivalents	4,454	5,936	119
Cash and cash equivalents, beginning of period	16,921	10,985	10,866
Cash and cash equivalents, end of period	$ 21,375	$ 16,921	$ 10,985
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,653	$ 1,704	$ 1,627
Cash paid for income taxes	3,966	4,935	3,542

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and "the Company") is a health care and well-being company with a mission to help people live healthier lives and help make the health system work better for everyone. Our two distinct, yet complementary business platforms—Optum and UnitedHealthcare—are working to help build a modern, high-performing health system through improved access, affordability, outcomes and experiences for the individuals and organizations we are privileged to serve.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to estimates and judgments for medical costs payable and goodwill. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premiums

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company's customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios (MLRs) as calculated under the definitions in the Patient Protection and Affordable Care Act (ACA) and related federal and state regulations and implementing regulation, falling below certain targets are required to rebate ratable portions of their premiums annually. Commercial premiums within the Company's individual and small group markets are also subject to the ACA risk adjustment program. Medicare Advantage premium revenue includes the impact of the Centers for Medicare & Medicaid Services (CMS) quality bonuses based on plans' Star rating. Certain of the Company's Medicaid business is also subject to state minimum MLR rebates.

Premium revenues are recognized based on the estimated premiums earned, net of projected rebates, because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues for certain value-based arrangements at its Optum Health care delivery businesses. Under these value-based arrangements, the Company enters into agreements with health plans to stand ready to deliver, integrate, direct and control certain health care services for the individuals enrolled. In exchange, the Company receives a premium that is typically paid on a per-member per-month basis. The Company considers these value-based arrangements to represent a single performance obligation where premium revenues are recognized in the period in which health care services are made available.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under CMS' risk adjustment payment methodology. CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis and encounter data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture and submit the necessary and available data to CMS within prescribed deadlines. The Company estimates risk adjustment premium revenues based upon the data submitted and expected to be submitted to CMS. Risk adjustment data for the Company's plans are subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Products and Services

For the Company's Optum Rx pharmacy care services business, the majority of revenues are derived from products sold through a contracted network of retail pharmacies or home delivery, specialty and community health pharmacies. Product revenues include the cost of pharmaceuticals (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's home delivery, specialty and community pharmacies. For the years ended December 31, 2021 and 2020, the Company recognized revenue and cost of products sold for retail pharmacy co-payments related to its Optum Rx business. Revenue recognized in prior periods related to retail pharmacy transactions excludes the member's applicable co-payment. There was no impact on earnings from operations, net earnings, earnings per share or total equity. Pharmacy products are billed to customers based on the number of transactions occurring during the billing period. Product revenues are recognized when the prescriptions are dispensed. The Company has entered into contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless of whether the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members and accordingly, are reported on a gross basis.

Services revenue are comprised of a number of services and products sold through Optum. Optum Health's service revenues include net patient service revenues recorded based upon established billing rates, less allowances for contractual adjustments, and are recognized as services are provided. For its financial services offerings, Optum Health charges fees and earns investment income on managed funds. Optum Insight provides software and information products, advisory consulting arrangements and managed services outsourcing contracts, which may be delivered over several years. Optum Insight revenues are generally recognized over time and measured each period based on the progress to date as services are performed or made available to customers.

Services revenue also consists of fees derived from services performed for customers who self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company receives monthly, a fixed fee per employee, which is recognized as revenue as the Company performs, or makes available, the applicable services to the customer. The customers retain the risk of financing health care costs for their employees and employees' dependents, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements. For these fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

As of December 31, 2021 and 2020, accounts receivables related to products and services were $5.4 billion and $5.3 billion, respectively. In 2021 and 2020, the Company had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the Consolidated Balance Sheets as of December 31, 2021 or 2020.

For the years ended December 31, 2021, 2020 and 2019, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price) was not material.

Revenue expected to be recognized in any future year related to remaining performance obligations, excluding revenue pertaining to contracts having an original expected duration of one year or less, contracts where revenue is recognized as invoiced and contracts with variable consideration related to undelivered performance obligations, is not material.

See Note 13 for disaggregation of revenue by segment and type.

Medical Costs and Medical Costs Payable

The Company's estimate of medical costs payable represents management's best estimate of its liability for unpaid medical costs as of December 31, 2021.

Each period, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months.

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services rendered on behalf of consumers, but for which claims have either not yet been received, processed, or paid. The Company develops estimates for medical care services incurred but not reported (IBNR), which includes estimates for claims which have not been received or fully processed, using an actuarial process consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim processing, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography. Judgments related to these factors contemplated the impact of COVID-19.

In developing its medical costs payable estimates, the Company applies different estimation methods depending on which incurred claims are being estimated. For the most recent two months, the Company estimates claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data are available, supplemented by a review of near-term completion factors (actuarial estimates, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period adjudicated by the Company at the date of estimation). For months prior to the most recent two months, the Company applies the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months.

Cost of Products Sold

The Company's cost of products sold includes the cost of pharmaceuticals dispensed to unaffiliated customers either directly at its home delivery, specialty and community pharmacy locations, or indirectly through its nationwide network of participating pharmacies. Rebates attributable to unaffiliated clients are accrued as rebates receivable and a reduction of cost of products sold, with a corresponding payable for the amounts of the rebates to be remitted to those unaffiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. Cost of products sold also includes the cost of personnel to support the Company's transaction processing services, system sales, maintenance and professional services.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments having an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available. Equity investments, with certain exceptions, are measured at fair value with changes in fair value recognized in net earnings.

The Company excludes unrealized gains and losses on investments in available-for-sale debt securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of equity. To calculate realized gains and losses on the sale of debt securities, the Company specifically identifies the cost of each investment sold.

The Company evaluates an available-for-sale debt security for credit-related impairment by considering the present value of expected cash flows relative to a security's amortized cost, the extent to which fair value is less than amortized cost, the financial condition and near-term prospects of the issuer and specific events or circumstances which may influence the operations of the issuer. Credit-related impairments are recorded as an allowance, with an offset to investment and other income. Non-credit related impairments are recorded through other comprehensive income. If the Company intends to sell an impaired security, or will likely be required to sell a security before recovery of the entire amortized cost, the entire impairment is included in net earnings.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the Company's investment policy.

Assets Under Management

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the AARP Program) and to AARP members and non-members under separate Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP Program include supplemental Medicare benefits, hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

Pursuant to the Company's agreement with AARP, program assets are managed separately from the Company's general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon any transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to the entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts, accrued interest and other miscellaneous amounts due to the Company.

The Company's pharmacy care services businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its affiliated and unaffiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The pharmacy care services businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms and record rebates attributable to affiliated clients as a reduction to medical costs. The Company generally receives rebates two to five months after billing. As of December 31, 2021 and 2020, total pharmaceutical manufacturer rebates

receivable included in other receivables in the Consolidated Balance Sheets amounted to $7.2 billion and $6.3 billion, respectively.

As of December 31, 2021 and 2020, the Company's Medicare Part D receivables amounted to $3.4 billion and $2.9 billion, respectively.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 10 years
Buildings	35 to 40 years
Capitalized software	3 to 5 years

Leasehold improvements are depreciated over the shorter of the remaining lease term or their estimated useful economic life.

Operating Leases

The Company leases facilities and equipment under long-term operating leases which are non-cancelable and expire on various dates. At the lease commencement date, lease right-of-use (ROU) assets and lease liabilities are recognized based on the present value of the future minimum lease payments over the lease term, which includes all fixed obligations arising from the lease contract. If an interest rate is not implicit in a lease, the Company utilizes its incremental borrowing rate for a period closely matching the lease term.

The Company's ROU assets are included in other assets, and lease liabilities are included in other current liabilities and other liabilities in the Company's Consolidated Balance Sheet.

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs impairment tests. The Company may first assess qualitative factors to determine if it is more likely than not the carrying value of a reporting unit exceeds its estimated fair value. The Company may also elect to skip the qualitative testing and proceed directly to the quantitative testing. When performing quantitative testing, the Company first estimates the fair values of its reporting units using discounted cash flows or a weighted combination of discounted cash flows and a market-based method. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, discount rates and the selection of comparable peer companies. If the fair value is less than the carrying value of the reporting unit, an impairment is recognized for the difference, up to the carrying amount of goodwill.

There was no impairment of goodwill during the years ended December 31, 2021, 2020 and 2019.

Intangible Assets

The Company's intangible assets are subject to impairment tests when events or circumstances indicate an intangible asset (or asset group) may be impaired. The Company's indefinite-lived intangible assets are also tested for impairment annually. There was no impairment of intangible assets during the years ended December 31, 2021, 2020 and 2019.

Other Current Liabilities

Other current liabilities include health savings account deposits ($11.4 billion and $10.2 billion as of December 31, 2021 and 2020, respectively), accruals for premium rebates payable, the RSF associated with the AARP Program, the current portion of future policy benefits and customer balances.

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short duration customer contracts are primarily charged to expense as incurred.

Redeemable Noncontrolling Interests

Redeemable noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The following table provides details of the Company's redeemable noncontrolling interests' activity for the years ended December 31, 2021 and 2020:

(in millions)	2021	2020
Redeemable noncontrolling interests, beginning of period	$ 2,211	$1,726
Net earnings	87	112
Acquisitions	28	321
Redemptions	(1,338)	—
Distributions	(255)	(149)
Fair value and other adjustments	701	201
Redeemable noncontrolling interests, end of period	$ 1,434	$2,211

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably, primarily over four years and compensation expense related to restricted shares is based on the share price on the date of grant. Stock options vest ratably primarily over four years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options is based on the fair value at the date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP), eligible employees are allowed to purchase the Company's stock at a discounted price, which is 90% of the market price of the Company's common stock at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic earnings per common share attributable to UnitedHealth Group common shareholders by dividing net earnings attributable to UnitedHealth Group common shareholders by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share attributable to UnitedHealth Group common shareholders using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, restricted shares and the ESPP (collectively, common stock equivalents), using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise and the average unrecognized compensation cost. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

ACA Tax

The Health Insurance Tax was permanently repealed by Congress, effective January 1, 2021. The permanent repeal of the tax impacts year-over-year comparability of our financial statements, including revenues, operating costs, medical care ratio (MCR), operating cost ratio, effective tax rate and cash flows from operations.

3. Investments

A summary of debt securities by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2021				
Debt securities—available-for-sale:				
U.S. government and agency obligations	$ 3,206	$ 23	$ (31)	$ 3,198
State and municipal obligations	6,829	297	(20)	7,106
Corporate obligations	20,947	372	(145)	21,174
U.S. agency mortgage-backed securities	5,868	88	(55)	5,901
Non-U.S. agency mortgage-backed securities	2,819	42	(23)	2,838
Total debt securities—available-for-sale	39,669	822	(274)	40,217
Debt securities—held-to-maturity:				
U.S. government and agency obligations	511	2	(2)	511
State and municipal obligations	30	2	—	32
Corporate obligations	100	—	—	100
Total debt securities—held-to-maturity	641	4	(2)	643
Total debt securities	$ 40,310	$ 826	$ (276)	$40,860
December 31, 2020				
Debt securities—available-for-sale:				
U.S. government and agency obligations	$ 3,335	$ 133	$ (3)	$ 3,465
State and municipal obligations	6,893	435	—	7,328
Corporate obligations	18,886	863	(12)	19,737
U.S. agency mortgage-backed securities	6,849	245	(3)	7,091
Non-U.S. agency mortgage-backed securities	2,116	95	(4)	2,207
Total debt securities—available-for-sale	38,079	1,771	(22)	39,828
Debt securities—held-to-maturity:				
U.S. government and agency obligations	420	6	—	426
State and municipal obligations	31	2	—	33
Corporate obligations	187	1	—	188
Total debt securities—held-to-maturity	638	9	—	647
Total debt securities	$ 38,717	$ 1,780	$ (22)	$40,475

Nearly all of the Company's investments in mortgage-backed securities were rated "Triple A" as of December 31, 2021. The Company held $3.5 billion and $2.3 billion of equity securities as of December 31, 2021 and 2020, respectively. The Company's investments in equity securities primarily consist of employee savings plan related investments, other venture investments and shares of Brazilian real denominated fixed-income funds with readily determinable fair values. Additionally, the Company's investments included $1.3 billion of equity method investments in operating businesses in the health care sector, as of both December 31, 2021 and 2020. The allowance for credit losses on held-to-maturity securities as of December 31, 2021 and 2020 was not material.

The amortized cost and fair value of debt securities as of December 31, 2021, by contractual maturity, were as follows:

(in millions)	Available-for-Sale		Held-to-Maturity	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	$ 2,603	$ 2,614	$ 235	$236
Due after one year through five years	12,885	13,065	355	354
Due after five years through ten years	11,342	11,524	28	29
Due after ten years	4,152	4,275	23	24
U.S. agency mortgage-backed securities	5,868	5,901	—	—
Non-U.S. agency mortgage-backed securities	2,819	2,838	—	—
Total debt securities	$ 39,669	$40,217	$ 641	$643

The fair value of available-for-sale debt securities with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

(in millions)	Less Than 12 Months		12 Months or Greater		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2021						
U.S. government and agency obligations	$ 1,976	$ (18)	$ 249	$ (13)	$ 2,225	$ (31)
State and municipal obligations	1,386	(19)	31	(1)	$ 1,417	$ (20)
Corporate obligations	9,357	(130)	376	(15)	9,733	(145)
U.S. agency mortgage-backed securities	3,078	(52)	116	(3)	3,194	(55)
Non-U.S. agency mortgage-backed securities	1,321	(18)	114	(5)	1,435	(23)
Total debt securities—available-for-sale	$17,118	$ (237)	$ 886	$ (37)	$18,004	$ (274)
December 31, 2020						
U.S. government and agency obligations	$ 346	$ (3)	$ —	$ —	$ 346	$ (3)
Corporate obligations	1,273	(9)	456	(3)	1,729	(12)
U.S. agency mortgage-backed securities	601	(3)	—	—	601	(3)
Non-U.S. agency mortgage-backed securities	195	(1)	93	(3)	288	(4)
Total debt securities—available-for-sale	$ 2,415	$ (16)	$ 549	$ (6)	$ 2,964	$ (22)

The Company's unrealized losses from all securities as of December 31, 2021 were generated from approximately 13,000 positions out of a total of 39,000 positions. The Company believes it will collect the timely principal and interest due on its debt securities having an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities which impacted the Company's assessment on collectability of principal and interest. At each reporting period, the Company evaluates available-for-sale debt securities for any credit-related impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the expected cash flows, the underlying credit quality and credit ratings of the issuers noting no significant credit deterioration since purchase. As of December 31, 2021, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary. The allowance for credit losses on available-for-sale debt securities as of December 31, 2021 and 2020 was not material.

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input which is significant to

the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1—Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2—Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs corroborated by other observable market data.

Level 3—Unobservable inputs cannot be corroborated by observable market data.

There were no transfers in or out of Level 3 financial assets or liabilities during the years ended December 31, 2021 or 2020.

Nonfinancial assets and liabilities or financial assets and liabilities measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. For the year ended December 31, 2021, the Company recognized $840 million of unrealized gains in investment and other income related to fair value adjustments on equity securities primarily in our venture portfolio, based on transactions of the same or similar security. There were no other significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2021 or 2020.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments which do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs currently observable in the markets for similar securities. Inputs often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and nonbinding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment to the prices obtained from the pricing service.

Fair values of debt securities which do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in corporate bonds, which are not a significant portion of our investments, are estimated using valuation techniques relying heavily on management assumptions and qualitative observations.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on such understanding.

Assets Under Management. Assets under management consists of debt securities and other investments held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Long-Term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2021				
Cash and cash equivalents	$ 21,359	$ 16	$ —	$ 21,375
Debt securities—available-for-sale:				
U.S. government and agency obligations	3,017	181	—	3,198
State and municipal obligations	—	7,106	—	7,106
Corporate obligations	40	20,916	218	21,174
U.S. agency mortgage-backed securities	—	5,901	—	5,901
Non-U.S. agency mortgage-backed securities	—	2,838	—	2,838
Total debt securities—available-for-sale	3,057	36,942	218	40,217
Equity securities	2,090	23	64	2,177
Assets under management	1,972	2,376	101	4,449
Total assets at fair value	$ 28,478	$ 39,357	$ 383	$ 68,218
Percentage of total assets at fair value	42%	57%	1%	100%
December 31, 2020				
Cash and cash equivalents	$ 16,841	$ 80	$ —	$ 16,921
Debt securities—available-for-sale:				
U.S. government and agency obligations	3,241	224	—	3,465
State and municipal obligations	—	7,328	—	7,328
Corporate obligations	25	19,424	288	19,737
U.S. agency mortgage-backed securities	—	7,091	—	7,091
Non-U.S. agency mortgage-backed securities	—	2,207	—	2,207
Total debt securities—available-for-sale	3,266	36,274	288	39,828
Equity securities	1,795	33	—	1,828
Assets under management	1,774	2,250	52	4,076
Total assets at fair value	$ 23,676	$ 38,637	$ 340	$ 62,653
Percentage of total assets at fair value	38%	61%	1%	100%

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2021					
Debt securities—held-to-maturity	$ 534	$ 102	$ 7	$ 643	$ 641
Long-term debt and other financing obligations	$ —	$ 52,583	$ —	$52,583	$46,003
December 31, 2020					
Debt securities—held-to-maturity	$ 466	$ 108	$ 73	$ 647	$ 638
Long-term debt and other financing obligations	$ —	$ 51,254	$ —	$51,254	$42,171

The carrying amounts reported on the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2021	December 31, 2020
Land and improvements	$ 502	$ 533
Buildings and improvements	4,882	4,759
Computer equipment	1,851	1,767
Furniture and fixtures	2,014	1,787
Less accumulated depreciation	(3,857)	(3,364)
Property and equipment, net	5,392	5,482
Capitalized software	5,712	5,010
Less accumulated amortization	(2,135)	(1,866)
Capitalized software, net	3,577	3,144
Total property, equipment and capitalized software, net	$ 8,969	$ 8,626

Depreciation expense for property and equipment for the years ended December 31, 2021, 2020 and 2019 was $996 million, $997 million and $995 million, respectively. Amortization expense for capitalized software for the years ended December 31, 2021, 2020 and 2019 was $923 million, $814 million and $721 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	Optum Health	Optum Insight	Optum Rx	Consolidated
Balance at January 1, 2020	$ 27,228	$ 15,342	$ 8,292	$ 14,797	$ 65,659
Acquisitions	1,180	4,500	—	699	6,379
Foreign currency effects and other adjustments, net.	(623)	2	(119)	39	(701)
Balance at December 31, 2020	27,785	19,844	8,173	15,535	71,337
Acquisitions	60	4,648	96	—	4,804
Foreign currency effects and other adjustments, net.	(456)	(268)	350	28	(346)
Balance at December 31, 2021	$ 27,389	$ 24,224	$ 8,619	$ 15,563	$ 75,795

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

(in millions)	December 31, 2021 Gross Carrying Value	Accumulated Amortization	Net Carrying Value	December 31, 2020 Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related	$ 13,011	$ (4,697)	$ 8,314	$ 13,428	$ (4,575)	$ 8,853
Trademarks and technology	1,630	(739)	891	1,597	(624)	973
Trademarks and other indefinite-lived	617	—	617	680	—	680
Other	422	(200)	222	606	(256)	350
Total	$ 15,680	$ (5,636)	$ 10,044	$ 16,311	$ (5,455)	$ 10,856

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

(in millions, except years)	2021 Fair Value	2021 Weighted-Average Useful Life	2020 Fair Value	2020 Weighted-Average Useful Life
Customer-related	$ 484	9 years	$1,113	11 years
Trademarks and technology	147	5 years	514	10 years
Other	29	11 years	95	10 years
Total acquired finite-lived intangible assets	$ 660	8 years	$1,722	11 years

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2022	$1,098
2023	1,033
2024	972
2025	892
2026	757

Amortization expense relating to intangible assets for the years ended December 31, 2021, 2020 and 2019 was $1.2 billion, $1.1 billion and $1.0 billion, respectively.

7. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2021	2020	2019
Medical costs payable, beginning of period	$ 21,872	$ 21,690	$ 19,891
Acquisitions	88	316	679
Reported medical costs:			
Current year	188,631	160,276	157,020
Prior years	(1,720)	(880)	(580)
Total reported medical costs	186,911	159,396	156,440
Medical payments:			
Payments for current year	(165,524)	(139,974)	(137,155)
Payments for prior years	(18,864)	(19,556)	(18,165)
Total medical payments	(184,388)	(159,530)	(155,320)
Medical costs payable, end of period	$ 24,483	$ 21,872	$ 21,690

For the years ended December 31, 2021, 2020 and 2019 medical cost reserve development was primarily driven by lower than expected health system utilization levels. Additionally, medical cost reserve development in the year ended December 31, 2021 was driven by the uncertainty of care patterns due to the disruption of the health care system caused by COVID-19.

Medical costs payable included IBNR of $17.1 billion and $14.8 billion at December 31, 2021 and 2020, respectively. Substantially all of the IBNR balance as of December 31, 2021 relates to the current year. The following is information about incurred and paid medical cost development as of December 31, 2021:

(in millions) Year	Net Incurred Medical Costs For the Years Ended December 31, 2020	2021
2020	$ 160,276	$ 159,140
2021		188,631
Total		$ 347,771

(in millions) Year	Net Cumulative Medical Payments For the Years Ended December 31, 2020	2021
2020	$ (139,974)	$ (158,182)
2021		(165,524)
Total		(323,706)
Net remaining outstanding liabilities prior to 2020		418
Total medical costs payable		$ 24,483

8. Short-Term Borrowings and Long-Term Debt

Short-term borrowings and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	Carrying Value As of December 31, 2021	2020
Commercial paper	$ —	$ 1,296
$400 million 4.700% notes due February 2021	—	400
$750 million 2.125% notes due March 2021	—	750
$350 million Floating rate notes due June 2021	—	350
$400 million 3.150% notes due June 2021	—	400
$500 million 3.375% notes due November 2021	—	507
$750 million 2.875% notes due December 2021	—	762
$1,100 million 2.875% notes due March 2022	1,097	1,113
$1,000 million 3.350% notes due July 2022	999	999
$900 million 2.375% notes due October 2022	899	897
$15 million 0.000% notes due November 2022	14	14
$625 million 2.750% notes due February 2023	632	644
$750 million 2.875% notes due March 2023	768	789
$750 million 3.500% notes due June 2023	749	748
$750 million 3.500% notes due February 2024	748	747
$1,000 million 0.550% notes due May 2024	996	—
$750 million 2.375% notes due August 2024	748	747
$2,000 million 3.750% notes due July 2025	1,994	1,992
$300 million 3.700% notes due December 2025	299	298
$500 million 1.250% notes due January 2026	497	496
$1,000 million 3.100% notes due March 2026	997	997
$1,000 million 1.150% notes due May 2026	972	—
$750 million 3.450% notes due January 2027	747	747
$625 million 3.375% notes due April 2027	621	620
$950 million 2.950% notes due October 2027	942	940
$1,150 million 3.850% notes due June 2028	1,144	1,143
$850 million 3.875% notes due December 2028	844	844
$1,000 million 2.875% notes due August 2029	1,023	1,086
$1,250 million 2.000% notes due May 2030	1,235	1,234
$1,500 million 2.300% notes due May 2031	1,482	—
$1,000 million 4.625% notes due July 2035	993	992
$850 million 5.800% notes due March 2036	839	839
$500 million 6.500% notes due June 2037	492	492
$650 million 6.625% notes due November 2037	642	641
$1,100 million 6.875% notes due February 2038	1,078	1,077
$1,250 million 3.500% notes due August 2039	1,242	1,241
$1,000 million 2.750% notes due May 2040	966	964
$300 million 5.700% notes due October 2040	296	296
$350 million 5.950% notes due February 2041	346	346
$1,500 million 3.050% notes due May 2041	1,483	—
$600 million 4.625% notes due November 2041	589	589
$502 million 4.375% notes due March 2042	485	485
$625 million 3.950% notes due October 2042	608	608
$750 million 4.250% notes due March 2043	736	735
$2,000 million 4.750% notes due July 2045	1,974	1,974
$750 million 4.200% notes due January 2047	739	738
$725 million 4.250% notes due April 2047	718	717
$950 million 3.750% notes due October 2047	934	934
$1,350 million 4.250% notes due June 2048	1,330	1,330
$1,100 million 4.450% notes due December 2048	1,087	1,086
$1,250 million 3.700% notes due August 2049	1,236	1,235
$1,250 million 2.900% notes due May 2050	1,209	1,208
$2,000 million 3.250% notes due May 2051	1,970	—
$1,250 million 3.875% notes due August 2059	1,228	1,228
$1,000 million 3.125% notes due May 2060	965	965
Total short-term borrowings and long-term debt	$44,632	$42,280

The Company's long-term debt obligations also included $1.4 billion and $1.2 billion of other financing obligations, of which $611 million and $354 million were current as of December 31, 2021 and 2020, respectively.

Maturities of short-term borrowings and long-term debt for the years ending December 31 are as follows:

(in millions)	
2022	$ 3,626
2023	2,277
2024	2,652
2025	2,452
2026	2,652
Thereafter	32,829

Short-Term Borrowings

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers.

The Company has $5.6 billion five-year, $5.6 billion three-year and $3.8 billion 364-day revolving bank credit facilities with 24 banks, which mature in December 2026, December 2024 and December 2022, respectively. These facilities provide full liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of December 31, 2021, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on one-month Term Secured Overnight Financing Rate (SOFR) plus a SOFR Adjustment of 10 basis points plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of December 31, 2021, annual interest rates would have ranged from 0.8% to 0.9%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including requiring the Company to maintain a debt to debt-plus-shareholders' equity ratio of not more than 60%. The Company was in compliance with its debt covenants as of December 31, 2021.

9. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2021	2020	2019
Current Provision:			
Federal	$3,451	$4,098	$2,629
State and local	481	392	319
Foreign	516	491	564
Total current provision	4,448	4,981	3,512
Deferred provision (benefit)	130	(8)	230
Total provision for income taxes	$4,578	$4,973	$3,742

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	2021		2020		2019	
Tax provision at the U.S. federal statutory rate	$4,685	21.0%	$4,356	21.0%	$3,776	21.0%
State income taxes, net of federal benefit	419	1.9	315	1.5	271	1.5
Share-based awards—excess tax benefit	(100)	(0.4)	(130)	(0.6)	(132)	(0.7)
Non-deductible compensation	144	0.6	134	0.7	119	0.7
Health insurance tax	—	—	626	3.0	—	—
Foreign rate differential	(246)	(1.1)	(164)	(0.8)	(214)	(1.2)
Other, net	(324)	(1.5)	(164)	(0.8)	(78)	(0.5)
Provision for income taxes	$4,578	20.5%	$4,973	24.0%	$3,742	20.8%

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2021	2020
Deferred income tax assets:		
Accrued expenses and allowances	$ 723	$ 815
U.S. federal and state net operating loss carryforwards	287	276
Share-based compensation	117	98
Nondeductible liabilities	296	252
Non-U.S. tax loss carryforwards	435	340
Lease liability	1,284	1,200
Other-domestic	228	126
Other-non-U.S.	376	454
Subtotal	3,746	3,561
Less: valuation allowances	(198)	(170)
Total deferred income tax assets	3,548	3,391
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(2,658)	(2,588)
Non-U.S. goodwill and intangible assets	(512)	(606)
Capitalized software	(833)	(731)
Depreciation and amortization	(349)	(346)
Prepaid expenses	(256)	(216)
Outside basis in partnerships	(565)	(342)
Lease right-of-use asset	(1,267)	(1,179)
Net unrealized gains on investments	(125)	(400)
Other-non-U.S.	(248)	(350)
Total deferred income tax liabilities	(6,813)	(6,758)
Net deferred income tax liabilities	$(3,265)	$(3,367)

Valuation allowances are provided when it is considered more likely than not deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Gross federal net operating loss carryforwards of $42 million expire beginning in 2023 through 2037 and $295 million have an indefinite carryforward period; state net operating loss carryforwards expire beginning in 2022 through 2041, with some having an indefinite carryforward period. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2021, the Company's undistributed earnings from non-U.S. subsidiaries are intended to be indefinitely reinvested in non-U.S. operations, and therefore no U.S. deferred taxes have been recorded. Taxes payable on the remittance of such earnings would be minimal.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2021	2020	2019
Gross unrecognized tax benefits, beginning of period	$1,829	$1,423	$1,056
Gross increases:			
Current year tax positions	538	416	512
Prior year tax positions	10	120	2
Gross decreases:			
Prior year tax positions	(47)	(130)	(96)
Settlements	—	—	(46)
Statute of limitations lapses	(20)	—	(5)
Gross unrecognized tax benefits, end of period	$2,310	$1,829	$1,423

The Company believes it is reasonably possible its liability for unrecognized tax benefits will decrease in the next twelve months by $42 million as a result of audit settlements and the expiration of statutes of limitations.

The Company classifies net interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Statements of Operations. During the years ended December 31, 2021, 2020 and 2019, the Company recognized $66 million, $52 million and $19 million of net interest and penalties, respectively. The Company had $194 million and $128 million of accrued interest and penalties for uncertain tax positions as of December 31, 2021 and 2020, respectively. These amounts are not included in the reconciliation above. As of December 31, 2021, there were $1.2 billion of unrecognized tax benefits which, if recognized, would affect the effective tax rate.

The Company currently files income tax returns in the United States, various states and localities and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2016 and prior. The Company's 2017 through 2020 tax years are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to the 2014 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2015 and forward.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated insurance and health maintenance organization (HMO) subsidiaries are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions which may be paid to their parent companies. In the United States, most of these state regulations and standards are generally consistent with model regulations established by the National Association of Insurance Commissioners. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

For the year ended December 31, 2021, the Company's domestic insurance and HMO subsidiaries paid their parent companies dividends of $8.0 billion, including $4.7 billion of extraordinary dividends. For the year ended December 31, 2020, the Company's domestic insurance and HMO subsidiaries paid their parent companies dividends of $8.3 billion, including $4.2 billion of extraordinary dividends.

The Company's global financially regulated subsidiaries had estimated aggregate statutory capital and surplus of $30.7 billion as of December 31, 2021. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's global financially regulated subsidiaries was approximately $13.0 billion as of December 31, 2021.

Optum Bank must meet minimum capital requirements of the Federal Deposit Insurance Corporation (FDIC) under the capital adequacy rules to which it is subject. At December 31, 2021, the Company believes Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2018, the Board renewed the Company's share repurchase program with an authorization to repurchase up to 100 million shares of its common stock.

A summary of common share repurchases for the years ended December 31, 2021 and 2020 is as follows:

	Years Ended December 31,	
(in millions, except per share data)	**2021**	**2020**
Common share repurchases, shares	13	14
Common share repurchases, average price per share	$389.92	$300.58
Common share repurchases, aggregate cost	$ 5,000	$ 4,250
Board authorized shares remaining	45	58

Dividends

In June 2021, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of $5.80 compared to $5.00 per share, which the Company had paid since June 2020. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of the Company's 2021 dividend payments:

Payment Date	**Amount per Share**	**Total Amount Paid**
		(in millions)
March 23	$ 1.25	$ 1,181
June 29	1.45	1,367
September 21	1.45	1,367
December 14	1.45	1,365

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options and restricted shares. As of December 31, 2021, the Company had 64 million shares available for future grants of share-based awards under the 2020 Stock Incentive Plan. In June 2021, the Company's shareholders approved 15 million additional shares under the ESPP. As of December 31, 2021, there were 18 million shares of common stock available for issuance under the ESPP.

Stock Options

Stock option activity for the year ended December 31, 2021 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	28	$ 211		
Granted	5	329		
Exercised	(7)	175		
Forfeited	(1)	297		
Outstanding at end of period	25	241	6.3	$ 6,610
Exercisable at end of period	12	179	4.7	3,932
Vested and expected to vest, end of period	25	240	6.2	6,509

Restricted Shares

Restricted share activity for the year ended December 31, 2021 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	4	$ 256
Granted	2	352
Vested	(2)	246
Nonvested at end of period	4	303

Other Share-Based Compensation Data

	For the Years Ended December 31,		
(in millions, except per share amounts)	2021	2020	2019
Stock Options			
Weighted-average grant date fair value of shares granted, per share	$ 71	$ 54	$ 46
Total intrinsic value of stock options exercised	1,519	1,736	1,398
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	352	303	259
Total fair value of restricted shares vested	$ 560	$ 574	$ 545
Employee Stock Purchase Plan			
Number of shares purchased	1	1	1
Share-Based Compensation Items			
Share-based compensation expense, before tax	$ 800	$ 679	$ 697
Share-based compensation expense, net of tax effects	719	619	641
Income tax benefit realized from share-based award exercises	173	208	201

(in millions, except years)	December 31, 2021
Unrecognized compensation expense related to share awards	$ 905
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options were as follows:

	For the Years Ended December 31,		
	2021	2020	2019
Risk-free interest rate	0.7% - 1.2%	0.2% - 1.4%	1.5% - 2.5%
Expected volatility	29.2% - 29.8%	22.2% - 29.5%	19.4% - 21.6%
Expected dividend yield	1.3% - 1.5%	1.4% - 1.7%	1.4% - 1.8%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	4.8	5.1	5.3

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option exercises and forfeitures within the valuation model. The expected lives of options granted represents the period of time the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2021, 2020 and 2019.

In addition, the Company maintains non-qualified, deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus. The deferrals are recorded within long-term investments with an approximately equal amount in other liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $1.8 billion and $1.6 billion as of December 31, 2021 and 2020, respectively.

12. Commitments and Contingencies

Leases

Operating lease costs were $1.2 billion, $1.1 billion and $1.0 billion for the years ended December 31, 2021, 2020 and 2019, respectively, and included immaterial variable and short-term lease costs for the year ended December 31, 2021, 2020 and 2019. Cash payments made on the Company's operating lease liabilities were $921 million, $865 million and $746 million for the years ended December 31, 2021, 2020 and 2019, respectively, which were classified within operating activities in the Consolidated Statements of Cash Flows. As of December 31, 2021, the Company's weighted-average remaining lease term and weighted-average discount rate for its operating leases were 8.7 years and 2.9%, respectively.

As of December 31, 2021, future minimum annual lease payments under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2022	$ 870
2023	763
2024	616
2025	510
2026	407
Thereafter	1,716
Total future minimum lease payments	4,882
Less imputed interest	(609)
Total	$ 4,273

Other Commitments

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2021, 2020 or 2019.

As of December 31, 2021, the Company had outstanding, undrawn letters of credit with financial institutions of $181 million and surety bonds outstanding with insurance companies of $1.3 billion, primarily to bond contractual performance.

Pending Acquisitions

In 2021, we entered into agreements to acquire multiple companies in the health care sector, most notably, Change Healthcare (NASDAQ: CHNG), subject to regulatory approval and other customary closing conditions. Additionally, in January 2022, we entered into agreements to acquire multiple companies in the health care sector, subject to regulatory approval and other customary closing conditions. The total anticipated capital required for these acquisitions, excluding the payoff of acquired indebtedness, is approximately $12 billion.

Legal Matters

The Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable a loss may be incurred.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice (DOJ), the SEC, the IRS, the U.S. Drug Enforcement Administration, the U.S. Department of Labor, the FDIC, the Defense Contract Audit Agency and other governmental authorities. Similarly, our international businesses are also subject to investigations, audits and reviews by applicable foreign governments, including South American and other non-U.S. governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans.

On February 14, 2017, the DOJ announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, DOJ moved to dismiss the

Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome which may result from this matter given its procedural status.

13. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics, products and services, customers, distribution methods and operational processes which operate in a similar regulatory environment are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global. The U.S. businesses share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology and consumer engagement infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses, sole proprietorships and individuals nationwide. UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State provides diversified health care benefits products and services to state programs caring for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, the Children's Health Insurance Program and other federal, state and community health care programs. UnitedHealthcare Global provides health and dental benefits and hospital and clinical services to employer groups and individuals in South America, and other diversified global health businesses.
- *Optum Health* focuses on care delivery, care management, wellness and consumer engagement, and health financial services. Optum Health is building a comprehensive, connected health care delivery and engagement platform by directly providing high-quality care, helping people manage chronic and complex health needs, and proactively engaging consumers in managing their health through in-person, in-home, virtual and digital clinical platforms. Optum Health offers access to networks of care provider specialists, health management services, care delivery, consumer engagement and financial services.
- *Optum Insight* brings together advanced analytics, technology and health care expertise to deliver integrated services and solutions. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations comprising the health care industry depend on Optum Insight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.
- *Optum Rx* offers pharmacy care services and programs, including retail network contracting, home delivery, specialty and community health pharmacy services, purchasing and clinical capabilities, and develops programs in areas such as step therapy, formulary management, drug adherence and disease/drug therapy management. Optum Rx integrates pharmacy and medical care and is positioned to serve patients with complex clinical needs and consumers looking for a better digital pharmacy experience with transparent pricing.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy care products and services to UnitedHealthcare customers by Optum Rx, certain product offerings and care management and local and in-home care delivery services sold to UnitedHealthcare by Optum Health, and health information and technology

solutions, consulting and other services sold to UnitedHealthcare by Optum Insight. These transactions are recorded at management's estimate of fair value. Transactions with affiliated customers are eliminated in consolidation. Assets and liabilities jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned so each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 36%, 36% and 33% for 2021, 2020 and 2019, respectively, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 97%, 97% and 96% of consolidated total revenues for 2021, 2020 and 2019, respectively. Long-lived fixed assets located in the United States represented approximately 78% and 75% of the total long-lived fixed assets as of December 31, 2021 and 2020, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Global.

The following table presents the reportable segment financial information:

(in millions)	UnitedHealthcare	Optum					Corporate and Eliminations	Consolidated
		Optum Health	Optum Insight	Optum Rx	Optum Eliminations	Optum		
2021								
Revenues—unaffiliated customers:								
Premiums	$ 212,381	$ 13,852	$ —	$ —	$ —	$ 13,852	$ —	$ 226,233
Products	—	32	159	34,246	—	34,437	—	34,437
Services	9,661	9,894	3,936	1,112	—	14,942	—	24,603
Total revenues—unaffiliated customers	222,042	23,778	4,095	35,358	—	63,231	—	285,273
Total revenues—affiliated customers	—	29,234	7,867	55,779	(2,013)	90,867	(90,867)	—
Investment and other income	857	1,053	237	177	—	1,467	—	2,324
Total revenues	$ 222,899	$ 54,065	$ 12,199	$ 91,314	$ (2,013)	$155,565	$ (90,867)	$ 287,597
Earnings from operations	$ 11,975	$ 4,462	$ 3,398	$ 4,135	$ —	$ 11,995	$ —	$ 23,970
Interest expense	—	—	—	—	—	—	(1,660)	(1,660)
Earnings before income taxes	$ 11,975	$ 4,462	$ 3,398	$ 4,135	$ —	$ 11,995	$ (1,660)	$ 22,310
Total assets	$ 102,967	$ 60,474	$ 16,868	$ 40,181	$ —	$117,523	$ (8,284)	$ 212,206
Purchases of property, equipment and capitalized software	795	791	567	301	—	1,659	—	2,454
Depreciation and amortization	1,004	818	684	597	—	2,099	—	3,103
2020								
Revenues—unaffiliated customers:								
Premiums	$ 191,679	$ 9,799	$ —	$ —	$ —	$ 9,799	$ —	$ 201,478
Products	—	33	135	33,977	—	34,145	—	34,145
Services	8,464	6,815	3,687	1,050	—	11,552	—	20,016
Total revenues—unaffiliated customers	200,143	16,647	3,822	35,027	—	55,496	—	255,639
Total revenues—affiliated customers	—	22,481	6,941	52,420	(1,800)	80,042	(80,042)	—
Investment and other income	732	680	39	51	—	770	—	1,502
Total revenues	$ 200,875	$ 39,808	$ 10,802	$ 87,498	$ (1,800)	$136,308	$ (80,042)	$ 257,141
Earnings from operations	$ 12,359	$ 3,434	$ 2,725	$ 3,887	$ —	$ 10,046	$ —	$ 22,405
Interest expense	—	—	—	—	—	—	(1,663)	(1,663)
Earnings before income taxes	$ 12,359	$ 3,434	$ 2,725	$ 3,887	$ —	$ 10,046	$ (1,663)	$ 20,742
Total assets	$ 98,229	$ 52,073	$ 15,425	$ 39,280	$ —	$106,778	$ (7,718)	$ 197,289
Purchases of property, equipment and capitalized software	687	715	461	188	—	1,364	—	2,051
Depreciation and amortization	920	703	670	598	—	1,971	—	2,891
2019								
Revenues—unaffiliated customers:								
Premiums	$ 183,783	$ 5,916	$ —	$ —	$ —	$ 5,916	$ —	$ 189,699
Products	—	31	116	31,450	—	31,597	—	31,597
Services	8,922	5,732	3,630	689	—	10,051	—	18,973
Total revenues—unaffiliated customers	192,705	11,679	3,746	32,139	—	47,564	—	240,269
Total revenues—affiliated customers	—	17,966	6,239	42,093	(1,661)	64,637	(64,637)	—
Investment and other income	1,137	672	21	56	—	749	—	1,886
Total revenues	$ 193,842	$ 30,317	$ 10,006	$ 74,288	$ (1,661)	$112,950	$ (64,637)	$ 242,155
Earnings from operations	$ 10,326	$ 2,963	$ 2,494	$ 3,902	$ —	$ 9,359	$ —	$ 19,685
Interest expense	—	—	—	—	—	—	(1,704)	(1,704)
Earnings before income taxes	$ 10,326	$ 2,963	$ 2,494	$ 3,902	$ —	$ 9,359	$ (1,704)	$ 17,981
Total assets	$ 88,250	$ 40,444	$ 15,181	$ 36,346	$ —	$ 91,971	$ (6,332)	$ 173,889
Purchases of property, equipment and capitalized software	841	573	495	162	—	1,230	—	2,071
Depreciation and amortization	926	565	672	557	—	1,794	—	2,720

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) designed to provide reasonable assurance the information required to be disclosed by us in reports we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2021. Based upon their evaluation, our Chief Executive Officer and Chief Financial Officer concluded our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2021.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2021 which have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control Over Financial Reporting as of December 31, 2021

Management of UnitedHealth Group Incorporated and Subsidiaries (the Company) is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2021. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in Internal Control-Integrated Framework (2013). Based on our assessment and the COSO criteria, we believe that, as of December 31, 2021, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2021, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2021, based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2021, based on criteria established in Internal Control—Integrated Framework (2013) issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2021, of the Company and our report dated February 15, 2022, expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2021. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 15, 2022

ITEM 9B. OTHER INFORMATION

None.

ITEM 9C. DISCLOSURE REGARDING FOREIGN JURISDICTIONS THAT PREVENT INSPECTIONS

Not Applicable.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

DIRECTORS OF THE REGISTRANT

The following sets forth certain information regarding our directors as of February 15, 2022, including their name and principal occupation or employment:

Richard T. Burke
Chief Executive Officer and Chair
Senior Connect Acquisition Corp.

Timothy P. Flynn
Retired Chair
KPMG International

Paul. R Garcia
Retired Chair and Chief Executive Officer
Global Payments Inc.

Stephen J. Hemsley
Chair
UnitedHealth Group

Michele J. Hooper
Lead Independent Director
UnitedHealth Group
President and Chief Executive Officer
The Directors' Council

F. William McNabb III
Former Chairman and Chief Executive Officer
The Vanguard Group, Inc.

Valerie C. Montgomery Rice, M.D.
President and Chief Executive Officer
Morehouse School of Medicine

John H. Noseworthy, M.D.
Former Chief Executive Officer and President
Mayo Clinic

Gail R. Wilensky, Ph.D.
Senior Fellow
Project HOPE

Andrew P. Witty
Chief Executive Officer
UnitedHealth Group

Pursuant to General Instruction G(3) to Form 10-K and the Instruction to Item 401 of Regulation S-K, information regarding our executive officers is provided in Part I, Item 1 under the caption "Information About our Executive Officers."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller and persons performing similar functions. The code of ethics, entitled Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at www.unitedhealthgroup.com. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business." We intend to satisfy the SEC's disclosure requirements regarding amendments to, or waivers of, the code of ethics for our senior financial officers by posting such information on our website indicated above.

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance" and "Proposal 1-Election of Directors" in our definitive proxy statement for our 2022 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402 and 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance—Risk Oversight" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2022 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information as of December 31, 2021, concerning shares of common stock authorized for issuance under all of our equity compensation plans:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(in millions)		(in millions)
Equity compensation plans approved by shareholders[1]	25	$ 241	82[3]
Equity compensation plans not approved by shareholders[2]	—		—
Total[2]	25	$ 241	82

(1) Consists of the UnitedHealth Group Incorporated 2020 Stock Incentive Plan, as amended and the UnitedHealth Group 1993 Employee Stock Purchase Plan, as amended.

(2) Excludes 111,000 shares underlying stock options assumed by us in connection with acquisitions. These options have a weighted-average exercise price of $282 and an average remaining term of approximately 3 years. These options are administered pursuant to the terms of the plans under which the options originally were granted. No future awards will be granted under these acquired plans.

(3) Includes 18 million shares of common stock available for future issuance under the 1993 Employee Stock Purchase Plan as of December 31, 2021, and 64 million shares available under the 2020 Stock Incentive Plan as of December 31, 2021. Shares available under the 2020 Stock Incentive Plan may become the subject of future awards in the form of stock options, stock appreciation rights, restricted stock, restricted stock units, performance awards and other stock-based awards.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2022 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2022 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Disclosure of Fees Paid to Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2022 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBIT AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2021 and 2020.
- Consolidated Statements of Operations for the years ended December 31, 2021, 2020, and 2019.
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2021, 2020, and 2019.
- Consolidated Statements of Changes in Equity for the years ended December 31, 2021, 2020, and 2019.
- Consolidated Statements of Cash Flows for the years ended December 31, 2021, 2020, and 2019.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

- Schedule I—Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

(b) The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

EXHIBIT INDEX**

3.1	Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A, Commission File No. 1-10864, filed on July 1, 2015)
3.2	Amended and Restated Bylaws of UnitedHealth Group Incorporated, effective February 23, 2021 (incorporated by reference to Exhibit 3.2 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on February 26, 2021)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated as of November 15, 1988, amended as of November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)

4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
4.5	Description of Common Stock (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.1	UnitedHealth Group 2020 Stock Incentive Plan (incorporated by UnitedHealth Group 2020 Stock Incentive Plan (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8, SEC File Number 333-238854, filed on June 1, 2020)
*10.2	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan
*10.3	Form of Agreement for Nonqualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan
*10.4	Form of Agreement for Performance-Based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan
*10.5	Form of Agreement for Restricted Stock Unit Award under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (Witty)
*10.6	Form of Agreement for Nonqualified Stock Option Award under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (Witty)
*10.7	Form of Agreement for Performance-Based Restricted Stock Unit Award under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (Witty)
*10.8	Form of Agreement for Restricted Stock Unit Award under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (Short)
*10.9	Form of Agreement for Nonqualified Stock Option Award under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (Short)
*10.10	Form of Agreement for Performance-Based Restricted Stock Unit Award under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (Short)
*10.11	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan
*10.12	Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on July 1, 2015)
*10.13	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.14	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.15	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.16	Second Amendment, dated as of November 5, 2015, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.17	UnitedHealth Group Executive Savings Plan (2021 Statement) (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2020)

*10.18	Summary of Non-Management Director Compensation, effective as of September 1, 2020 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2020)
*10.19	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.20	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009)
*10.21	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.22	Catamaran Corporation Third Amended and Restated Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.23	Catalyst Health Solutions, Inc. 2006 Stock Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.24	Audax Health Solutions, Inc. 2010 Equity Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 to Registration Statement on Form S-8, SEC File Number 333-205826, filed on February 15, 2017)
*10.25	Surgical Care Affiliates, Inc. 2016 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.26	Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.27	Surgical Care Affiliates, Inc. Management Equity Incentive Plan (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.28	Surgical Care Affiliates, Inc. Directors and Consultants Equity Incentive Plan (incorporated by reference to Exhibit 4.6 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.29	The Advisory Board Company Amended and Restated 2009 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on June 15, 2015)
*10.30	The Advisory Board Company 2005 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on November 17, 2005)
*10.31	Amended and Restated Employment Agreement, effective as of December 1, 2014, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.32	Amendment to Employment Agreement, effective as of August 16, 2017, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017)
*10.33	Amended and Restated Employment Agreement, dated as of June 7, 2016, between United HealthCare Services, Inc. and John Rex (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)

*10.34	Amended and Restated Employment Agreement, dated February 3, 2021, between the Company and Andrew P Witty (incorporated by reference to Exhibit 5.02 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on February 8, 2021)
*10.35	Amended and Restated Employment Agreement, effective as of March 16, 2015, between United HealthCare Services, Inc. and Dirk McMahon (incorporated by reference to Exhibit 10.44 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.36	Amendment to Employment Agreement, effective as of May 31, 2017, between United HealthCare Services, Inc. and Dirk McMahon (incorporated by reference to Exhibit 10.45 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.37	Amendment to Employment Agreement, effective as of March 12, 2019, between United HealthCare Services, Inc. and Dirk McMahon (incorporated by reference to Exhibit 10.46 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.38	Amended and Restated Employment Agreement, effective as of February 12, 2018, between United HealthCare Services, Inc. and Brian R. Thompson
*10.39	Employment Agreement, effective as of January 1, 2013, between United HealthCare Services, Inc. and Marianne D. Short (incorporated by reference to Exhibit 10.34 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.40	Amendment to Employment Agreement, effective as of June 5, 2018, between United HealthCare Services, Inc. and Marianne D. Short
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data")
21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS	XBRL Instance Document—the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document.
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document.
104	Cover Page Interactive Data File (formatted as Inline XBRL and embedded within Exhibit 101).

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* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

Schedule I—Condensed Financial Information of Registrant (Parent Company Only).

Schedule I

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statement Schedule

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2021 and 2020, and for each of the three years in the period ended December 31, 2021, and the Company's internal control over financial reporting as of December 31, 2021, and have issued our reports thereon dated February 15, 2022; such reports are included elsewhere in this Form 10-K. Our audits also included the financial statement schedule of the Company listed in the Index at Item 15. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statement schedule based on our audits. In our opinion, the financial statement schedule, when considered in relation to the consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 15, 2022

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2021	December 31, 2020
Assets		
Current assets:		
Cash and cash equivalents	$ 2,167	$ 258
Other current assets	503	562
Total current assets	2,670	820
Equity in net assets of subsidiaries	116,907	107,714
Long-term notes receivable from subsidiaries	5,680	5,021
Other assets	32	342
Total assets	$ 125,289	$ 113,897
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 605	$ 589
Current portion of notes payable to subsidiaries	8,105	4,882
Short-term borrowings and current maturities of long-term debt	3,009	4,465
Total current liabilities	11,719	9,936
Long-term debt, less current maturities	41,623	37,815
Other liabilities	187	655
Total liabilities	53,529	48,406
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value—10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value—3,000 shares authorized; 941 and 946 issued and outstanding	10	10
Additional paid-in capital	—	—
Retained earnings	77,134	69,295
Accumulated other comprehensive loss	(5,384)	(3,814)
Total UnitedHealth Group shareholders' equity	71,760	65,491
Total liabilities and shareholders' equity	$ 125,289	$ 113,897

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2021	2020	2019
Revenues:			
Investment and other income	$ 494	$ 194	$ 209
Total revenues	494	194	209
Operating costs:			
Operating costs	40	27	38
Interest expense	1,583	1,594	1,580
Total operating costs	1,623	1,621	1,618
Loss before income taxes	(1,129)	(1,427)	(1,409)
Benefit for income taxes	231	300	293
Loss of parent company	(898)	(1,127)	(1,116)
Equity in undistributed income of subsidiaries	18,183	16,530	14,955
Net earnings	17,285	15,403	13,839
Other comprehensive (loss) income	(1,570)	(236)	582
Comprehensive income	$15,715	$15,167	$14,421

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2021	2020	2019
Operating activities			
Cash flows from operating activities	$11,439	$ 8,842	$ 9,275
Investing activities			
Issuances of notes to subsidiaries	(444)	(628)	(2,722)
Repayments of notes to subsidiaries	37	1,089	2,249
Cash paid for acquisitions	(4,953)	(7,706)	(9,645)
Return of capital to parent company	245	943	4,497
Capital contributions to subsidiaries	(747)	(43)	(803)
Other, net	—	143	490
Cash flows used for investing activities	(5,862)	(6,202)	(5,934)
Financing activities			
Common stock repurchases	(5,000)	(4,250)	(5,500)
Proceeds from common stock issuances	1,355	1,440	1,037
Cash dividends paid	(5,280)	(4,584)	(3,932)
(Repayments of) proceeds from short-term borrowings, net	(1,302)	872	300
Proceeds from issuance of long-term debt	6,933	4,864	5,444
Repayments of long-term debt	(3,150)	(3,150)	(1,750)
Proceeds from notes from subsidiaries	3,223	2,818	1,207
Other, net	(447)	(438)	(535)
Cash flows used for financing activities	(3,668)	(2,428)	(3,729)
Increase (decrease) in cash and cash equivalents	1,909	212	(388)
Cash and cash equivalents, beginning of period	258	46	434
Cash and cash equivalents, end of period	$ 2,167	$ 258	$ 46
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,575	$ 1,633	$ 1,506
Cash paid for income taxes	3,050	4,185	2,590

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements.and Supplementary Data."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends and Capital Distributions. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $10.8 billion, $10.0 billion and $5.6 billion in 2021, 2020 and 2019, respectively. Additionally, $0.2 billion, $0.9 billion and $4.5 billion in cash were received as a return of capital to the parent company during 2021, 2020 and 2019, respectively.

3. Short-Term Borrowings and Long-Term Debt

Discussion of short-term borrowings and long-term debt can be found in Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data." Long-term debt obligations of the parent company do not include other financing obligations at subsidiaries which totaled $1.4 billion and $1.2 billion at December 31, 2021 and 2020.

Maturities of short-term borrowings and long-term debt for the years ending December 31 are as follows:

(in millions)	
2022	$ 3,015
2023	2,125
2024	2,500
2025	2,300
2026	2,500
Thereafter	32,677

UnitedHealth Group's parent company had notes payable to subsidiaries of $8.1 billion and $4.9 billion as of December 31, 2021 and 2020, respectively, which included on-demand features.

4. Commitments and Contingencies

Certain regulated subsidiaries are guaranteed by UnitedHealth Group's parent company in the event of insolvency. UnitedHealth Group's parent company also provides guarantees related to its service level under certain contracts. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2021, 2020 or 2019.

For a summary of commitments and contingencies, see Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements.and Supplementary Data"

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Dated: February 15, 2022

UNITEDHEALTH GROUP INCORPORATED

By /s/ Andrew P. Witty

Andrew P. Witty
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Andrew P. Witty **Andrew P. Witty**	Director and Chief Executive Officer (principal executive officer)	February 15, 2022
/s/ John F. Rex **John F. Rex**	Executive Vice President and Chief Financial Officer (principal financial officer)	February 15, 2022
/s/ Thomas E. Roos **Thomas E. Roos**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 15, 2022
* **Richard T. Burke**	Director	February 15, 2022
* **Timothy P. Flynn**	Director	February 15, 2022
* **Paul R. Garcia**	Director	February 15, 2022
* **Stephen J. Hemsley**	Director	February 15, 2022
* **Michele J. Hooper**	Director	February 15, 2022
* **F. William McNabb III**	Director	February 15, 2022
* **Valerie C. Montgomery Rice, M.D.**	Director	February 15, 2022
* **John H. Noseworthy, M.D.**	Director	February 15, 2022
* **Gail R. Wilensky, Ph.D.**	Director	February 15, 2022

*By /s/ Dannette L. Smith

Dannette L. Smith
As Attorney-in-Fact

UnitedHealth Group Form 10-K – 2020

Parent Company Audited Financial Statements

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2020

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission file number: 1-10864

UNITEDHEALTH GROUP®

UnitedHealth Group Incorporated

(Exact name of registrant as specified in its charter)

Delaware	**41-1321939**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center 9900 Bren Road East Minnetonka, Minnesota	
(Address of principal executive offices)	**55343 (Zip Code)**

(952) 936-1300

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $.01 par value	**UNH**	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one)

Large accelerated filer ☒
Non-accelerated filer ☐
Accelerated filer ☐
Smaller reporting company ☐
Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2020 was $281,771,756,077 (based on the last reported sale price of $294.95 per share on June 30, 2020, on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 29, 2021, there were 945,319,404 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2021 Annual Meeting of Shareholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

Table of Contents

PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

The terms "we," "our," "us," "its," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

UnitedHealth Group is a diversified health care company with a mission to help people live healthier lives and help make the health system work better for everyone.

- We seek to enhance the performance of the health system and improve the overall health and well-being of the people we serve and their communities.
- We work with health care professionals and other key partners to expand access to quality health care, so people get the care they need at an affordable price.
- We support the patient-physician relationship and empower people with the information, guidance and tools they need to make personal health choices and decisions.

Our two complementary businesses—Optum and UnitedHealthcare—are driven by this unified mission and vision to improve health care access, affordability, experiences and outcomes for the individuals and organizations we are privileged to serve. The breadth and scope of our diversified company help to consistently improve health care quality, access and affordability. Our ability to analyze complex data and apply deep health care expertise and insights allows us to serve people, care providers, businesses, communities and governments with more innovative products and complete, end-to-end offerings for many of the biggest challenges facing health care today.

Optum is an information and technology-enabled health services businesses delivering services to help modernize the health system and improve overall population health. Optum serves the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units to help improve overall health system performance through optimizing care quality, reducing costs and improving consumer experience and care provider performance, leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations.

UnitedHealthcare offers a full spectrum of health benefit programs. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and individual consumers. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare Global provides health and dental benefits and hospital and clinical services to employer groups and individuals in South America, and other diversified global health businesses.

Through Optum and UnitedHealthcare, in 2020, we processed nearly a trillion dollars in gross billed charges and we managed more than $250 billion in aggregate health care spending on behalf of the customers and consumers we serve. Our revenues are derived from premiums on risk-based products; product revenues from pharmacy care services; fees from care delivery, management, administrative, technology, consulting and managed outsourced services; sales of a wide variety of products and services related to the broad health care industry; and investment and other income. Our two business platforms have four reportable segments:

- OptumHealth;
- OptumInsight;

- OptumRx; and
- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global.

Optum

Optum is an information and technology-enabled health services business serving the broad health care marketplace, including:

- Those who need care: the consumers who need the right support, information, resources and products to achieve their health goals.
- Those who provide care: pharmacies, hospitals, physicians, practices and other health care facilities seeking to modernize the health system and support the best possible patient care and experiences.
- Those who pay for care: employers; health plans; and state, federal and municipal agencies devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently and effectively.
- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines to improve care delivery and health outcomes.

Optum operates three business segments leveraging distinctive capabilities in health care delivery, population health, health care operations, data and analytics and pharmacy care services:

- OptumHealth focuses on care delivery, care management, wellness and consumer engagement, and health financial services;
- OptumInsight offers data, analytics, research, consulting, technology and managed services solutions; and
- OptumRx provides a diversified array of pharmacy care services.

OptumHealth

OptumHealth provides health and wellness care, addressing the physical, emotional and health-related financial needs of 98 million consumers, through a national health care delivery platform which engages people in the most appropriate care settings, including their homes. OptumHealth helps patients and providers navigate and address complex, chronic and behavioral health needs; delivers local primary, specialty, surgical and urgent care; offers post-acute care planning services; and serves consumers and care providers through advanced, on-demand digital health technologies, such as telehealth and remote patient monitoring, and innovative health care financial services. OptumHealth works directly with consumers, care delivery systems, employers, payers, and government entities to improve quality, patient and provider satisfaction while lowering cost.

OptumHealth enables care providers' transition from traditional fee-for-service payment models to performance-based delivery and payment models to improve patient health and outcomes. Through strategic partnerships, alliances and ownership arrangements, OptumHealth helps care providers adopt new approaches and technologies improving the coordination of care across providers to more comprehensively serve patients.

Optum Financial, including Optum Bank, serves consumers through 7.6 million health savings and other accounts and has more than $16 billion in assets under management as of December 31, 2020. During 2020, Optum Financial processed $178 billion in digital medical payments to physicians and other health care providers. Organizations across the health system rely on Optum to manage and improve payment flows through its highly automated, scalable, digital payment systems.

OptumHealth offers its products on a risk basis, assuming responsibility for health care costs in exchange for a monthly premium, on an administrative fee basis, managing or administering products and services in exchange for a monthly fee, or on a fee-for-service basis, delivering medical services to patients in exchange for a contracted fee. For financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three key areas: employers including large, mid-sized and small employers; payers including health plans, TPAs, underwriter/stop-loss carriers and individual product intermediaries; and government entities including the U.S. Departments of Health and Human Services (HHS), Veterans Affairs, Defense, and other federal, state and local health care agencies.

OptumInsight

OptumInsight brings together advanced analytics, technology and health care expertise to deliver integrated services and solutions. Hospital systems, physicians, health plans, state governments, life sciences companies and other organizations comprising the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, advance quality, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system. OptumInsight serves the needs of health systems (e.g., physicians and hospital systems), health plans, state governments and life sciences companies.

Health Systems. Serves hospitals, physicians and other care providers to improve revenue and growth, better coordinate care and reduce administrative costs through technology and services to improve population health management, patient engagement, revenue cycle management and strategic growth plans.

Health Plans. Serves health plans by improving financial performance and enhancing outcomes through proactive analytics, a comprehensive payment integrity portfolio and staff-supported risk and quality services. OptumInsight helps health plans navigate a dynamic environment defined by shifts in employer vs. government-sponsored coverage, the demand for affordable benefit plans and the need to leverage new technology to reduce complexity.

State Governments. Provides advanced technology and analytics services to modernize the administration of critical safety net programs, such as Medicaid, while improving cost predictability.

Life Sciences Companies. Combines data and analytics expertise with comprehensive technologies and health care knowledge to help life sciences companies adopt a more comprehensive approach to advancing therapeutic discoveries and improving clinical outcomes.

Many of OptumInsight's software and information products and professional services are delivered over extended periods, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with OptumInsight's customers. OptumInsight's aggregate backlog as of December 31, 2020 was approximately $20.2 billion, of which $10.5 billion is expected to be realized within the next 12 months. The aggregate backlog includes $7.5 billion related to affiliated agreements. OptumInsight's aggregate backlog as of December 31, 2019, was $19.3 billion. OptumInsight cannot provide any assurance it will be able to realize all of the revenues included in the backlog due to uncertainties with regard to the timing and scope of services and the potential for cancellation, non-renewal or early termination of service arrangements.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface OptumInsight's products with their applications.

OptumRx

OptumRx provides a full spectrum of pharmacy care services through its network of more than 67,000 retail pharmacies, multiple home delivery, specialty and community health pharmacies and through the provision of in-home and pharmacy infusion services. OptumRx manages limited and ultra-limited distribution drugs in oncology, HIV, pain management and ophthalmology and serves the growing pharmacy needs of people with behavioral health and substance use disorders, particularly Medicare and Medicaid beneficiaries.

OptumRx's comprehensive whole-person approach to pharmacy care services integrates demographic, medical, laboratory, pharmaceutical and other clinical data and applies analytics to drive clinical care insight to support care treatments and compliance, benefiting clients and individual consumers through enhanced services, elevated clinical quality and cost trend management.

In 2020, OptumRx managed $105 billion in pharmaceutical spending, including $46 billion in specialty pharmaceutical spending.

OptumRx serves health benefits providers, large national employer plans, unions and trusts, purchasing coalitions and government entities. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

OptumRx offers multiple clinical programs, digital tools and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner which are designed to promote better health outcomes, and to help target inappropriate utilization and non-adherence to medication, each of which may result in adverse medical events affecting member health and client pharmacy and medical spend. OptumRx provides various utilization management, medication management, quality assurance, adherence and counseling programs to complement each client's plan design and clinical strategies. OptumRx offers a distinctive approach to integrating the management of medical and pharmaceutical care by using data and advanced analytics to help improve comprehensive decision-making, elevate quality, close gaps in care and reduce costs for customers and people served.

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, creating a better health care experience for its customers and helping to control rising health care costs. UnitedHealthcare's market position is built on:

- strong local-market relationships;
- the breadth of product offerings, based upon extensive expertise in distinct market segments in health care;
- service and advanced technology, including digital consumer engagement;
- competitive medical and operating cost positions;
- effective clinical engagement; and
- innovation for customers and consumers.

UnitedHealthcare utilizes Optum's capabilities to help coordinate and provide patient care, improve affordability of medical care, analyze cost trends, manage pharmacy care services, work with care providers more effectively and create a simpler and more satisfying consumer and physician experience.

In the United States, UnitedHealthcare arranges for discounted access to care through networks which, as of December 31, 2020, include 1.4 million physicians and other health care professionals and more than 6,500 hospitals and other facilities.

UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under "Government Regulation" and in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers a comprehensive array of consumer-oriented health benefit plans and services nationwide for large national employers, public sector employers, mid-sized employers, small businesses, and individual consumers. As of December 31, 2020, UnitedHealthcare Employer & Individual provides access to medical services for 26.2 million people on behalf of our customers and alliance partners, including employer customers, serving people across all 50 states, the District of Columbia and most U.S. territories. Products are offered through affiliates licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium which is typically a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers who elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision.

The consolidated purchasing capacity represented by the individuals served by UnitedHealth Group makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals and facilities. UnitedHealthcare Employer & Individual has relationships with network care providers who integrate data and analytics, implement value-based payments and care management programs and enable us to jointly better manage health care and improve quality across populations.

UnitedHealthcare Employer & Individual typically distributes its products through consultants or direct sales in the larger employer and public sector segments. In the smaller group segment of the commercial marketplace, UnitedHealthcare Employer & Individual's distribution system consists primarily of direct sales and sales through collaboration with brokers and agents. UnitedHealthcare Employer & Individual also distributes products through wholesale agents or agencies who contract with health insurance carriers to distribute individual or group benefits and provide other related services to their customers. In addition, UnitedHealthcare Employer & Individual distributes its products through professional employer organizations, associations and through both multi-carrier and its own proprietary private exchange marketplaces.

UnitedHealthcare Employer & Individual's diverse product portfolio offers employers a continuum of benefit designs, price points and approaches to consumer engagement which provides the flexibility to meet a full spectrum of their coverage needs.

UnitedHealthcare Employer & Individual's major product families include:

Consumer Engagement Products. Consumer engagement products couple plan design with financial accounts to increase individuals' responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings

accounts (HSAs) and consumer engagement services such as personalized behavioral incentive programs, consumer education and other digital offerings. We also offer and have been developing a variety of innovative consumer-centric products aligning with the unique needs and financial means of our customers, while engaging individuals in better managing their health.

Traditional Products. Traditional products include a full range of medical benefits and network options, and offer a spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy care services products which complement its service offerings by improving quality of care, engaging consumers and providing cost-saving options. Consumers served by UnitedHealthcare Employer & Individual can access clinical products to help them make better health care decisions and better use of their medical benefits which contribute to improved health and lowered medical expenses.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmacy care services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs offering improved value and outcomes, helping consumers take actions to improve their health and supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on offering type (risk-based or self-funded), line of business (e.g., small business, key accounts, public sector, national accounts or individual consumers) and clinical need. UnitedHealthcare Employer & Individual's clinical programs include:

- wellness programs;
- decision support;
- utilization management;
- case and disease management;
- complex condition management;
- on-site programs, including biometrics and flu shots;
- incentives to reinforce positive behavior change;
- mental health/substance use disorder management; and
- employee assistance programs.

Specialty Offerings. Through its broad network, UnitedHealthcare Employer & Individual delivers dental, vision, hearing and other specialty benefits, including accident protection, critical illness, disability and hospital indemnity offerings, using an integrated approach in private and retail settings.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services, as well as services dealing with chronic disease and other specialized issues common among older people. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia and most U.S. territories. UnitedHealthcare Medicare & Retirement has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products allowing people choice in obtaining the health coverage and services they need as their circumstances change. UnitedHealthcare Medicare & Retirement is positioned to serve seniors who find affordable, network-based care provided through Medicare Advantage plans meets their unique health care needs. For those who prefer traditional fee-for-service Medicare, UnitedHealthcare Medicare & Retirement offers both Medicare Supplement and Medicare Prescription Drug Benefit (Medicare Part D) programs to supplement their government-sponsored Medicare by providing additional benefits and coverage options. UnitedHealthcare Medicare & Retirement services include care management and health system navigator services, clinical management programs, nurse health line services, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients, including AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through agents, employer groups and digital channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by the Centers for Medicare & Medicaid Services (CMS), including Medicare Advantage HMO plans, Preferred Provider Organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, monthly consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which individuals reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. Medicare Advantage plans are designed to compete at the local level, taking into account consumer and care provider preferences, competitor offerings, our quality and cost initiatives, our historical financial results and the long-term payment rate outlook for each geographic area. UnitedHealthcare Medicare & Retirement served 5.7 million people through its Medicare Advantage products as of December 31, 2020.

Built on more than 20 years of experience, UnitedHealthcare Medicare & Retirement's senior-focused care management model operates at a medical cost level below traditional Medicare, while helping seniors live healthier lives. We have continued to enhance our offerings, focusing on more digital and physical care resources in the home, expanding our concierge navigation services and enabling the home as a safe and effective setting of care. For example, through our HouseCalls program, nurse practitioners performed nearly 1.7 million preventive care visits in 2020 to address unmet care opportunities and close gaps in care. Our Navigate4Me program provides a single point of contact and a direct line of support for individuals as they go through their health care experiences. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software and digital therapeutics for remote monitoring enabling clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information bridging across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify people at high risk and enable care managers to create individualized care plans to help them obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. The stand-alone Medicare Part D plans address a large spectrum of people's needs and preferences for their prescription drug coverage, including low-cost prescription options. Each of the plans includes the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2020, UnitedHealthcare enrolled 9.2 million people in the Medicare Part D programs, including 4.0 million individuals in stand-alone Medicare Part D plans, with the remainder in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving 4.5 million seniors nationwide through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at a diversity of price points. These products cover various levels of coinsurance and deductible gaps to which seniors are exposed in the traditional Medicare program.

Premium revenues from CMS represented 36% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2020, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs caring for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage, typically in exchange for a monthly premium per member from the state program. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, including Temporary Assistance to Needy Families (TANF); Children's Health Insurance Programs (CHIP); Dual SNPs (DSNPs); Long-Term Services and Supports (LTSS); Aged, Blind and Disabled; and other federal, state and community health care programs. As of December 31, 2020, UnitedHealthcare Community & State participated in programs in 31 states and the District of Columbia, and served 6.6 million people; including more than 1.1 million people through Medicaid expansion programs in 16 states under the Patient Protection and Affordable Care Act (ACA).

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation, including the state's commitment and consistency of support for its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates, commensurate with medical cost trends.

These health plans and care programs are designed to address the complex needs of the populations they serve, including the chronically ill, people with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in medically underserved areas and are less likely to have a consistent relationship with the medical community or a care provider. They also often face significant social and economic challenges.

UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group locally, supporting effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing national and local market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care and often addresses other social determinants affecting people's health status and health system usage.

Approximately 75% of the people in state Medicaid programs are served by managed care, but this population represents only approximately 50% of total Medicaid spending. UnitedHealthcare Community & State's business development opportunities include entering fee-for-service markets converting to managed care; and growing in existing managed care markets, including state expansions to populations with more complex needs requiring more sophisticated models of care, including DSNP and LTSS programs. Our offerings to state expansion cover more medically complex populations, including integrated care management of physical, behavioral, long-term care services and supports, and social services by applying strong data analytics and community-based collaboration.

UnitedHealthcare Community & State continues to evolve its clinical model to enhance quality and the clinical experience for the people it serves. The model enables UnitedHealthcare Community & State to quickly identify the people who could benefit most from more highly coordinated care.

UnitedHealthcare Global

UnitedHealthcare Global serves 7.6 million people with medical and dental benefits, typically in exchange for a monthly premium per member, residing principally in Brazil, Chile, Colombia and Peru, but also in 150 other countries. UnitedHealthcare Global serves multinational and local businesses, governments, insurers and individuals and their families through health insurance plans for local populations, care delivery services, benefit plans and risk and assistance solutions. UnitedHealthcare Global offers health care delivery in our principal markets through over 50 hospitals, and approximately 200 outpatient and ambulatory clinics and surgery centers to UnitedHealthcare Global members and consumers served by the external payer market.

In Brazil, Amil provides health benefits to 3.4 million people and dental benefits to more than 2.2 million people. Empresas Banmédica provides health benefits and health care services to approximately 2 million people in Chile, Colombia and Peru. Lusíadas Saúde provides clinical services to people in Portugal through an owned network of hospitals and outpatient clinics.

GOVERNMENT REGULATION

Our businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies who generally have discretion to issue regulations and interpret and enforce laws and rules. The regulations can vary significantly from jurisdiction to jurisdiction and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals which could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our business.

If we fail to comply with, or fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to our compliance with federal, state and international laws and regulations.

Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations, including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amounts of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to medical loss ratios (MLRs) and risk adjustment data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance and the regulatory environment with respect to these programs is complex. In addition, our business is subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriate reduction or limitation of health care services, anti-money laundering, securities and antitrust compliance.

Privacy, Security and Data Standards Regulation. Certain of our operations are subject to regulation under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), which apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets and for the privacy and security of protected health information.

Our businesses must comply with the Health Information Technology for Economic and Clinical Health Act (HITECH) which regulates matters relating to privacy, security and data standards. HITECH imposes requirements on uses and disclosures of health information; included contracting requirements for HIPAA business associate agreements; extends parts of HIPAA privacy and security provisions to business associates; adds federal data breach notification requirements for covered entities and business associates and reporting requirements to HHS and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthens enforcement and imposes higher financial penalties for HIPAA violations and, in certain cases, imposes criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate.

The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and generally prescribe safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations, which may apply to us, as discussed below. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations subject to periodic interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee health benefit plans, particularly those who maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for administration of benefits, claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations which where adopted by states, require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. We are required to maintain a risk management framework and file a confidential self-assessment report with state insurance regulators. We file reports annually with Connecticut, our lead regulator, and with New York, as required by the state's regulation. Certain states have also adopted their own regulations for minimum MLRs with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with the ACA, which may affect our operations and our financial results.

Our health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports

describing capital structure, ownership, financial condition, certain affiliated transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material affiliated transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, Managed Care Organization (MCO), utilization review (UR), TPA, pharmacy care services, durable medical equipment or care provider-related regulations and licensure requirements. These regulations differ from state to state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. There are laws and regulations which set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distribution laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies who oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible (for Medicare and Medicaid) beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

State Privacy and Security Regulations. A number of states have adopted laws and regulations which may affect our privacy and security practices, such as state laws governing the use, disclosure and protection of social security numbers and protected health information or are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to meet minimum cyber-security standards and notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Different approaches to state privacy and insurance regulation and varying enforcement philosophies may materially and adversely affect our ability to standardize our products and services across state lines. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws prohibiting specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from engaging in fee-splitting practices which involve sharing in the fees or revenues of a professional practice. These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation. The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Pharmacy and Pharmacy Benefits Management (PBM) Regulations

OptumRx’s businesses include home delivery, specialty and compounding pharmacies, as well as clinic-based pharmacies which must be licensed as pharmacies in the states in which they are located. Certain of our pharmacies must also register with the U.S. Drug Enforcement Administration (DEA) and individual state controlled substance authorities to dispense controlled substances. In addition to adhering to the laws and regulations in the states where our pharmacies are located, we also are required to comply with laws and regulations in some non-resident states where we deliver pharmaceuticals, including those requiring us to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our pharmacies to follow the laws of the state in which the pharmacies are located, but some non-resident states also require us to

comply with their laws where pharmaceuticals are delivered. Additionally, certain of our pharmacies participate in programs for Medicare and state Medicaid providers are required to comply with applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to our pharmacy care services businesses.

Federal and state legislation of PBM activities affect both our ability to limit access to a pharmacy provider network or remove network providers. Additionally, many states limit our ability to manage and establish maximum allowable costs for generic prescription drugs. With respect to formulary services, a number of government entities, including CMS, HHS and state departments of insurance, regulate the administration of prescription drug benefits offered through federal or state exchanges. Many states also regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. These regulations could limit or preclude (i) certain plan designs, (ii) limited networks, (iii) requirements to use particular care providers or distribution channel, (iv) copayment differentials among providers and (v) formulary tiering practices.

Legislation seeking to regulate PBM activities introduced or enacted at the federal or state level could impact our business practices with others in the pharmacy supply chain, including pharmaceutical manufacturers and network providers. Additionally, organizations like the NAIC periodically issue model regulations and credentialing organizations, like the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), may establish standards impacting PBM pharmacy activities. While these model regulations and standards do not have the force of law, they may influence states to adopt their recommendations and impact the services we deliver to our clients.

Consumer Protection Laws

Certain of our businesses participate in direct-to-consumer activities and are subject to regulations applicable to online communications and other general consumer protection laws and regulations such as the Federal Tort Claims Act, the Federal Postal Service Act and the FTC’s Telemarketing Sales Rule. Most states also have similar consumer protection laws.

Certain laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission (“FCC”) and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions which carries out annual examinations to ensure the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank’s compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

International Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes vary from jurisdiction to jurisdiction. In addition, our non-U.S. businesses and operations are subject to U.S. laws regulating the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health care company, we operate in highly competitive markets across the full expanse of health care benefits and services, including organizations ranging from startups to highly sophisticated Fortune 50 global enterprises, for-profit and non-profit companies, and private and government-sponsored entities. New entrants and business combinations also contribute to a dynamic and competitive environment. We compete fundamentally on the quality and value we provide to those we serve which can include elements such as product and service innovation; use of technology; consumer and provider engagement and satisfaction; sales, marketing and pricing. See Part I, Item 1A, “Risk Factors” for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, Optum and UnitedHealthcare names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim any proprietary interest in the marks and names of others.

HUMAN CAPITAL RESOURCES

Our 330,000 employees, as of December 31, 2020, including our more than 125,000 clinical professionals, are guided by our mission to help people live healthier lives and help make the health system work better for everyone. Our mission and cultural values of integrity, compassion, relationships, innovation and performance align with our long-term business strategy to increase access to care, make care more affordable, enhance the care experience and improve health outcomes. Our mission and values attract individuals who are determined to make a difference – individuals whose talent, innovation, engagement and empowerment are critical in our ability to achieve our mission.

We are committed to developing our people and culture by creating an inclusive environment where people of diverse backgrounds, experiences and perspectives make us better. Our approach is data-driven and leader led, including enterprise and business scorecards ensuring our leaders are accountable for a consistent focus on hiring, developing, advancing and retaining diverse talent. We have embedded inclusion and diversity throughout our culture, including in our talent acquisition and talent management practices; leadership development; careers; learning and skills; and systems and processes. We strive to maintain a sustainable and diverse talent pipeline by building strong strategic partnerships and outreach through early career programs, internships and apprenticeships. We support career coaching, mentorship and accelerated leadership development programs to ensure mobility and advancement for our diverse talent. To foster an engaged workforce and an inclusive culture, we invest in a broad array of learning and culture development programs. We rely on a shared leadership framework, which clearly and objectively defines our expectations, enables an environment where everyone has the opportunity to learn and grow, and helps us identify, develop and deploy talent driving us toward achieving our mission.

We prioritize pay equity by regularly evaluating and reviewing our compensation practices by gender, ethnicity and race. Receiving on-going feedback from our team members is another way we help strengthen and reinforce a culture of inclusion. Our Employee Experience Index measures an employee's sense of commitment and belonging to the Company and is a metric in the Stewardship section of our annual incentive plan. Our Sustainability Report, which can be accessed on our website at www.unitedheatlhgroup.com, provides further details on our people and culture.

INFORMATION ABOUT OUR EXECUTIVE OFFICERS

The following sets forth certain information regarding our executive officers as of March 1, 2021, including the business experience of each executive officer during the past five years:

Name	Age	Position
Andrew P. Witty	56	Chief Executive Officer; Chief Executive Officer of Optum
Dirk C. McMahon	61	President and Chief Operating Officer; Chief Executive Officer of UnitedHealthcare
John F. Rex	59	Executive Vice President; Chief Financial Officer
Thomas E. Roos	48	Senior Vice President; Chief Accounting Officer
Patricia L. Lewis	58	Executive Vice President; Chief Human Resources Officer

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Mr. Witty is Chief Executive Officer and a member of the Board of Directors of UnitedHealth Group and has served in these roles since February 2021. In addition, Mr. Witty is Chief Executive Officer of Optum and has served in this capacity since July 2018. Mr. Witty previously served as President of UnitedHealth Group from November 2019 to February 2021 and as a UnitedHealth Group director from August 2017 to March 2018. From April 2020 to November 2020, Mr. Witty took an unpaid leave of absence from his positions at UnitedHealth Group and Optum to serve as a Global Envoy for the World Health Organization's COVID-19 efforts. Prior to joining UnitedHealth Group, he was Chief Executive Officer and a board member of GlaxoSmithKline, a global pharmaceutical company, from 2008 to April 2017.

Mr. McMahon is President and Chief Operating Officer of UnitedHealth Group and has served in this capacity since February 2021. In addition, Mr. McMahon is Chief Executive Officer of UnitedHealthcare and has served in this capacity since June 2019. Mr. McMahon previously served as President and Chief Operating Officer of Optum from April 2017 to June 2019 and as Executive Vice President, Operations at UnitedHealth Group from November 2014 to April 2017. Mr. McMahon also served as Chief Executive Officer of OptumRx from November 2011 to November 2014. Prior to 2011, he held various positions in UnitedHealthcare in operations, technology and finance.

Mr. Rex is Executive Vice President and Chief Financial Officer of UnitedHealth Group and has served in this capacity since June 2016. From March 2012 to June 2016, Mr. Rex served as Executive Vice President and Chief Financial Officer of Optum. Prior to joining Optum in 2012, Mr. Rex was a Managing Director at JP Morgan, a global financial services firm.

Mr. Roos is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in this capacity since August 2015. Prior to joining UnitedHealth Group, Mr. Roos was a Partner at Deloitte & Touche LLP, an independent registered public accounting firm, from September 2007 to August 2015.

Ms. Lewis is Executive Vice President and Chief Human Resources Officer of UnitedHealth Group and has served in this capacity since October 2019. Prior to joining UnitedHealth Group, Ms. Lewis served at Lockheed

Martin where she was Senior Vice President and Chief Human Resources Officer from December 2014 to October 2019. Prior to joining Lockheed Martin Corporation, a global security and aerospace company, in 2011, Ms. Lewis held various positions in Human Resources at International Business Machines Corporation, a global technology company, and DuPont De Nemours, Inc, a global diversified chemicals company. Ms. Lewis currently serves as a director of Lear, Inc.

Additional Information

Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at www.unitedhealthgroup.com to learn more about our company. From the site you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our certificate of incorporation and bylaws; corporate governance policies, including our Principles of Governance; Board of Directors Committee Charters; Code of Conduct; and annual sustainability report. We make periodic reports and amendments available, free of charge, on our website, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Equiniti (EQ), can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: EQ Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, or telephone (800) 401-1957 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words “believe,” “expect,” “intend,” “estimate,” “anticipate,” “forecast,” “outlook,” “plan,” “project,” “should” or similar words or phrases are intended to identify such forward-looking statements. These statements are intended to take advantage of the “safe harbor” provisions of the PSLRA. These forward-looking statements involve risks and uncertainties which may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement in this report speaks only as of the date of this report and, except as required by law, we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business, which investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other public filings or statements we make

may turn out to be wrong. Our forward-looking statements can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. Many factors discussed below will be important in determining our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions which are difficult to predict or quantify.

Risks Related to Our Business and Our Industry

We are subject to risks associated with public health crises, large-scale medical emergencies and pandemics, such as the COVID-19 pandemic, which could have a material adverse effect on our business, results of operations, financial condition and financial performance.

The ongoing COVID-19 global health crisis continues to have major impacts on health systems, businesses, governments and customer and consumer activities. We have mobilized the full strength of our resources to deliver the best care for patients, support for our members and care provider partners, keep our employees safe and deliver innovative solutions and support for the communities we serve and the entire health system. The impact to our business is primarily dependent upon the ultimate pacing, intensity and duration of the crisis, and the timing for widespread availability and effectiveness of a vaccine, factors which remain uncertain at this time. These factors continue to affect the related treatment, testing, coverage and other services we provide for the people we serve. As the crisis abates, we may experience an increase in medical care costs as people seek care which was deferred during the pandemic and individuals with chronic conditions may require additional care needs resulting from missed treatments. The premiums and fees we charge, including premiums dependent upon documented health conditions, may not be sufficient to cover the medical and administrative costs associated with COVID-19 and other care services. In addition, we have experienced and may continue to experience reduced demand for certain services Optum provides to care providers, health plans and employers as a result of reduced clinical and claims activity and changes in business priorities resulting from COVID-19.

The COVID-19 pandemic has resulted in our customers having to close or severely curtail their operations. Among other impacts, we have experienced and may continue to experience loss of commercial and pharmacy care services members due to customer reductions in workforce and an adverse impact on the timing and collectability of premium payments. In addition, governments have modified, and may continue to modify, regulatory standards around various aspects of health care in response to COVID-19, and these changing standards may create challenges for us to ensure timely compliance and meet various contractual obligations.

Further disruptions in public and private infrastructure, including supply chains providing medical supplies and pharmaceutical products, could adversely disrupt our business operations or increase our operating costs. Additionally, the enactment of emergency powers by governments could disrupt our business operations, including restricting pharmaceuticals or other supplies, and could increase the risk of shortages of necessary items.

Although we cannot predict the pacing, intensity and duration of COVID-19, the pandemic's disruption to business activities, employment and economic effects, and near and long-term impacts on the patterns of care and services across the healthcare system could continue to have material and adverse effects on our business, results of operations, financial position or cash flows.

If we fail to estimate, price for and manage our medical costs in an effective manner, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our products

depends in large part on our ability to predict, price for and effectively manage medical costs. Our OptumHealth business negotiates risk-based arrangements with commercial third-party payers which are also included in premium revenues. Under a typical arrangement, OptumHealth receives a fixed percentage of a third-party payer's premiums to cover all or a defined portion of the medical costs provided to members. Premium revenues from risk-based products comprise nearly 80% of our total consolidated revenues. If we fail to predict accurately, or effectively price for or manage, the costs of providing care under risk-based arrangements, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of competitive provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies and Medicaid contracts is typically based on a fixed monthly rate per individual served for a 12-month period and is generally priced one to six months before the contract commences. Our revenue on Medicare policies is based on bids submitted to CMS in June the year before the contract year. Although we base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, large-scale medical emergencies, pandemics, such as COVID-19, the introduction of new or costly drugs, treatments and technology, new treatment guidelines, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2020 medical costs for commercial insured products had been 1% higher than our actual medical costs, without proportionally higher revenues from such products, our annual net earnings for 2020 would have been reduced by approximately $290 million, excluding any offsetting impact from risk adjustment or from reduced premium rebates due to minimum MLRs.

In addition, the financial results we report for any particular period include estimates of costs incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove inaccurate, our results of operations could be materially and adversely affected.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our business is highly dependent on the integrity and timeliness of the data we use to serve our members, customers and health care professionals and to operate our business. The volume of health care data generated, and the uses of data, including electronic health records, are rapidly expanding. Our ability to implement new and innovative services, price adequately our products and services, provide effective service to our customers in an efficient and uninterrupted fashion, and report accurately our results of operations depends on the integrity of the data in our information systems. In addition, connectivity among technologies is becoming increasingly important and recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences. If the data we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could experience failures in our health, wellness and information technology products; lose existing customers; have difficulty attracting new customers; experience problems in determining medical cost estimates and establishing appropriate pricing; have difficulty preventing, detecting and controlling fraud; have disputes with customers, physicians and other health care professionals; become subject to regulatory sanctions or penalties; incur increases in operating expenses or suffer other adverse consequences.

We periodically consolidate, integrate, upgrade and expand our information systems' capabilities as a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions. Our process of consolidating the number of systems we operate, upgrading and expanding our information systems' capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology may not be successful. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install software products which may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to health data and the health information technology market may alter the competitive landscape or present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we sustain cyber-attacks or other privacy or data security incidents resulting in security breaches disrupting our operations or resulting in the unintended dissemination of protected personal information or proprietary or confidential information, we could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences.

We routinely process, store and transmit large amounts of data in our operations, including protected personal information subject to privacy, security or data breach notification laws, as well as proprietary or confidential information relating to our business or third parties. Some of the data we process, store and transmit may be outside of the United States due to our information technology systems and international business operations. We are regularly the target of attempted cyber-attacks and other security threats and may be subject to breaches of the information technology systems we use. We have programs in place which are intended to detect, contain and respond to data security incidents and provide employee awareness training regarding phishing, malware and other cyber risks to protect against cyber risks and security breaches. However, because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and are increasing in sophistication, we may be unable to anticipate these techniques, detect breaches for long periods of time or implement adequate preventive measures. Experienced computer programmers and hackers may be able to penetrate our security controls and access, misappropriate or otherwise compromise protected personal information or proprietary or confidential information or that of third parties, create system disruptions or cause system shutdowns, negatively affecting our operations. They also may be able to develop and deploy viruses, worms and other malicious software programs attacking our systems or otherwise exploit any security vulnerabilities. Hardware, software, or applications we develop or procure from third parties may contain defects in design or manufacture or other problems which could unexpectedly compromise information security. In addition, we are subject to heightened vulnerability to cybersecurity attacks associated with increased numbers of employees working from home. Our facilities and services may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; financial fraud schemes; misplaced or lost data; human error; malicious social engineering; or other events which could negatively affect our systems, our customers' data, proprietary or confidential information relating to our business or third parties, or our operations. In certain circumstances we may rely on third-party vendors to process, store and transmit large amounts of data for our business whose operations are subject to similar risks.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be material. Our remediation efforts may not be successful and could result in interruptions, delays, or

cessation of service and loss of existing or potential customers. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information, proprietary information or confidential information about us or our customers or other third parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, result in litigation and liability, including regulatory penalties, for us, damage our brand and reputation, or otherwise harm our business.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States, South America and other foreign markets and face significant competition in all of the geographic markets in which we operate. In particular geographies or segments, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; lower profit margin or financial return expectations; or other factors which give such competitors a competitive advantage. Our competitive position may also be adversely affected by significant merger and acquisition activity in the industries in which we operate, both among our competitors and suppliers. Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability.

In addition, our success in the health care marketplace will depend on our ability to develop and deliver innovative and potentially disruptive products and services to satisfy evolving market demands. If we do not continue to innovate and provide products and services, which are useful and relevant to consumers and our customers, we may not remain competitive, and we risk losing market share to existing competitors and disruptive new market entrants. For example, new direct-to-consumer business models from competing businesses may make it more difficult for us to directly engage consumers in the selection and management of their health care benefits and health care usage. We may face challenges from new technologies and market entrants which could affect our existing relationship with health plan enrollees in these areas. Any failure by us to continue to develop innovative care models could result in competitive disadvantages and loss of market share. Our business, results of operations, financial position and cash flows could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services demonstrating value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals and other service providers, our business could be materially and adversely affected.

Our results of operations and prospects are substantially dependent on our continued ability to contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and other service providers at competitive prices. Any failure by us to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes, which may be costly, divert management's attention from our operations and result in negative publicity.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions which could result in higher medical costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician and hospital organizations or multi-specialty physician groups, may have

significant market positions or near monopolies which could result in diminished bargaining power on our part. In addition, ACOs; practice management companies (which aggregate physician practices for administrative efficiency); and other organizational structures adopted by physicians, hospitals and other care providers may change the way in which these providers do business with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our business, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

Our health care benefits businesses have risk-based arrangements with some physicians, hospitals and other health care providers. These arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent a risk-based health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the arrangement, we may be held responsible for unpaid health care claims which should have been the responsibility of the health care provider and for which we have already paid the provider. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with which we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers render services to our members who do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances the amount is either not defined or is established by a standard which does not clearly specify dollar terms. In some instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us.

The success of some of our businesses, including OptumHealth and UnitedHealthcare Global, depend on maintaining satisfactory relationships with physicians as our employees, independent contractors or joint venture partners. The physicians who practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. We face and will likely continue to face heightened competition in the markets where we operate to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with competitors of UnitedHealthcare. Our businesses could suffer if our affiliated physician organizations fail to maintain relationships with these companies, or fail to adequately price their contracts with these third-party payers.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and certain health care providers are customers of our Optum businesses. Physicians also provide medical services at facilities owned by our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

We are routinely subject to various legal actions due to the nature of our business, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

We are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include matters related to health care benefits coverage and payment claims (including disputes with enrollees, customers and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims (including claims related to the delivery of health care services, such as medical malpractice by staff at our affiliates' facilities, or by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), whistleblower claims (including claims under the False Claims Act or similar statutes), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We may also be party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we operate in jurisdictions outside of the United States where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. We are largely self-insured with regard to litigation risks. While we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible the level of actual losses will significantly exceed the liabilities recorded.

We cannot predict the outcome of significant legal actions in which we are involved and are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in some markets and businesses.

Any failure by us to manage successfully our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions or relationships domestically or outside the United States could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated which in turn could adversely impact our reputation, business and results of operations. Further, if we fail to identify and successfully complete transactions, which further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows.

Success in completing acquisitions is also dependent on effectively integrating the acquired business into our existing operations, including our internal control environment and culture, or otherwise leveraging its operations which may present challenges different from those presented by organic growth and may be difficult for us to manage. In addition, even with appropriate diligence, pre-acquisition practices of an acquired business may

expose us to legal challenges and investigations. For example, in January 2021, an indictment for alleged violations of antitrust laws was issued by the DOJ against our subsidiary, Surgical Care Affiliates (SCA), based on conduct alleged to have begun more than five years prior to our acquisition. We are vigorously defending this lawsuit, but if SCA is found liable, we may be subject to criminal fines or reputational harm. If we cannot successfully integrate these acquisitions and realize contemplated revenue growth opportunities and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we expand and operate our business outside of the United States, we are presented with challenges differing from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, languages, business, labor and cultural practices and regulatory environments. Adapting to these challenges could require us to devote significant senior management attention and other resources to the acquired businesses before we realize anticipated synergies or other benefits from the acquired businesses. These challenges vary widely by country and, outside of the United States, may include political instability, government intervention, discriminatory regulation and currency exchange controls or other restrictions, which could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate, or converting local currencies we hold into U.S. dollars or other currencies. If we are unable to manage successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our shareholders' equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through nonexclusive producers and consultants for whose services and allegiance we must compete. Our sales would be materially and adversely affected if we are unable to attract, retain and support such independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commission levels.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment has caused lower enrollment or lower rates of renewal in our employer group benefits and pharmacy services plans. Unfavorable economic conditions also have caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retroactively to apply to payments already negotiated or received from the

government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on health insurance and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, hospitals, care providers, employers and others which could, in turn, materially and adversely affect Optum's financial results.

Our failure to attract, develop, retain, and manage the succession of key employees and executives could adversely affect our business, results of operations and future performance.

We are dependent on our ability to attract, develop and retain qualified employees and executives, including those with diverse backgrounds, experiences and skill sets, to operate and expand our business. Experienced and highly skilled employees and executives in the health care and technology industries are in high demand and the market for their services is extremely competitive. We may have difficulty in replacing key executives because of the limited number of qualified individuals in these industries with the breadth of skills and experience required to operate and successfully expand our business. In addition, we believe our corporate culture fosters integrity, compassion, relationships, innovation and performance. Adverse changes to our corporate culture could harm our business operations and our ability to retain key employees and executives. While we have development and succession plans in place for our key employees and executives, these plans do not guarantee the services of our key employees and executives will continue to be available to us. If we are unable to attract, develop, retain and effectively manage the development and succession plans for key employees and executives, our business, results of operations and future performance could be adversely affected.

Our investment portfolio may suffer losses which could adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities which constitute the vast majority of the fair value of our investments as of December 31, 2020. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily issuers of our investments in corporate and municipal bonds), could reduce our investment income and require us to write down the value of our investments which could adversely affect our profitability and equity.

There can be no assurance our investments will produce total positive returns or we will not sell investments at prices which are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have an adverse effect on our results of operations and the capital position of our regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, equity and credit ratings could be materially and adversely affected.

As of December 31, 2020, our goodwill and other intangible assets had a carrying value of $82 billion, representing 42% of our total consolidated assets. We periodically evaluate our goodwill and other intangible

assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses we acquire perform in a manner inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and equity in the period in which the impairment occurs. A material decrease in equity could, in turn, adversely affect our credit ratings.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees and third parties, and our trademarks, trade secrets, copyrights and patents to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, and we expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this industry segment grows. Such litigation and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength and debt ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used by customers and creditors. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. There can be no assurance our current credit ratings will be maintained in the future. Any downgrades in our credit ratings could materially increase our costs of or ability to access funds in the debt capital markets and otherwise materially increase our operating costs.

Risks Related to the Regulation of Our Business

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related regulations and licensure requirements. Under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies who write the same line or similar lines of business. Any such assessment could expose our insurance entities and other insurers to the risk they would be required to pay a portion of an impaired or insolvent insurance company's claims through state guaranty associations.

Certain of our businesses provide products or services to various government agencies. For example, some of our Optum and UnitedHealthcare businesses hold government contracts or provide services related to government contracts and are subject to U.S. federal and state and non U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims and other laws and regulations governing government contractors and the use of government funds. Our relationships with these government agencies are subject to the terms of contracts we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies which might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations distinct from those faced by our insurance and HMO subsidiaries, some of which could impact our relationships with physicians, hospitals and customers. These regulations include state telemedicine regulations; debt collection laws; banking regulations; distributor and producer licensing requirements; state corporate practice of medicine doctrines; fee-splitting rules; and health care facility licensure and certificate of need requirements. These risks and uncertainties may materially and adversely affect our ability to market or provide our products and services, or to do so at targeted operating margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our businesses and interpretations of those laws and rules are subject to frequent change. For example, legislative, administrative and public policy changes to the ACA are being considered, and we cannot predict if the ACA will be further modified. Litigation challenges have been brought seeking to invalidate the ACA in whole or in part. A federal appeals court struck down the ACA as in part unconstitutional in 2019. During the fourth quarter of 2020, the Supreme Court heard oral arguments in the case. Further, the integration into our businesses of entities we acquire may affect the way in which existing laws and rules apply to us, including by subjecting us to laws and rules which did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our businesses could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We also must obtain and maintain regulatory approvals to market many of our products and services, increase prices for certain regulated products and services and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on all proposed rate increases on many of our products to HHS for monitoring purposes. Geographic and product expansions of our businesses may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) which vary by jurisdiction. We currently operate outside of the United States and in the future may acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our UnitedHealthcare Global business subjects us to Brazilian laws and regulations affecting hospitals, managed care and insurance industries and to regulation by Brazilian regulators, including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, while our Banmédica business is subject to Chilean, Colombian and Peruvian laws, regulations and regulators applicable to hospitals and private insurance. Any international regulator may take an approach to the interpretation, implementation and

enforcement of industry regulations which could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws regulating the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted operating margins which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations which could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive substantial revenues from these programs. Certain of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or termination of the contract at the option of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes which may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example, CMS has in the past reduced or frozen Medicare Advantage benchmarks, and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit.

Under the Medicaid managed care program, state Medicaid agencies seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members who were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs and other factors. If any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, implementation of material program or policy changes

after our bid submission, or submission by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of the ACA, CMS has a system providing various quality bonus payments to Medicare Advantage plans meeting certain quality star ratings at the individual plan or local contract level. The star rating system considers various measures adopted by CMS, including, among others, quality of care, preventive services, chronic illness management, handling of appeals and customer satisfaction. Plans must have a rating of four stars or higher to qualify for bonus payments. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial position and cash flows. Any changes in standards or care delivery models applying to government health care programs, including Medicare and Medicaid, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjustment of monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers for Medicare Advantage plans, as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Certain of our local plans have been selected for such audits, which in the past have resulted and in the future could result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS.

We have been and may in the future become involved in routine, regular and special governmental investigations, audits, reviews and assessments. Such investigations, audits, reviews or assessments sometimes arise out of, or prompt claims by private litigants or whistleblowers who, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false or erroneous claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which have resulted in, and in the future could result in, adverse publicity, the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

Our businesses providing pharmacy care services face regulatory and operational risks and uncertainties which may differ from the risks of our other businesses.

We provide pharmacy care services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback, beneficiary inducement and other laws governing the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. In addition, federal and state legislatures regularly consider new regulations for the industry which could materially affect current industry practices, including potential new legislation and regulations regarding the receipt or disclosure of rebates and other fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, the use of average wholesale prices or other pricing benchmarks, pricing for

specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies. Additionally, various governmental agencies have conducted investigations into certain PBM practices, which have resulted in other PBMs agreeing to civil penalties, including the payment of money and entry into corporate integrity agreements. As a provider of pharmacy benefit management services, OptumRx is also subject to an increasing number of licensure, registration and other laws and accreditation standards impacting the business practices of a pharmacy benefit manager. OptumRx also conducts business through home delivery, specialty and compounding pharmacies, pharmacies located in community mental health centers and home infusion, which subjects it to extensive federal, state and local laws and regulations, including those of the DEA and individual state controlled substance authorities, the Food and Drug Administration (FDA) and Boards of Pharmacy.

We could face potential claims in connection with purported errors by our home delivery, specialty or compounding or clinic-based pharmacies or the provision of home infusion services, including as a result of the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions from any of our home delivery, specialty pharmacy or home infusion services could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our pharmacy care services businesses provide services to sponsors of health benefit plans subject to ERISA. A private party or the DOL, which is the agency who enforces ERISA, could assert the fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy care services businesses even where those businesses are not contractually obligated to assume fiduciary obligations. If a court were to determine fiduciary obligations apply, we could be subject to claims for breaches of fiduciary obligations or claims we entered into certain prohibited transactions.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, including with respect to third-party service providers utilizing protected personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of protected personal information is regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations.

Internationally, many of the jurisdictions in which we operate have established their own data security and privacy legal framework with which we or our customers must comply. We expect there will continue to be new proposed laws, regulations and industry standards concerning privacy, data protection and information security in the European Union, Brazil, Chile, India and other jurisdictions, and we cannot yet determine the impacts such future laws, regulations and standards may have on our businesses or the businesses of our customers. For example, effective May 2018, the European Union's General Data Protection Regulation (GDPR) overhauled data protection laws in the European Union. The new regulation superseded prior European Union privacy and data protection legislation, imposed more stringent European Union data protection requirements on us or our customers, and prescribed greater penalties for noncompliance. Brazilian privacy legislation, similar in certain respects to GDPR, took effect in August 2020.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard designed to protect payment card account data.

HIPAA requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and,

as a result, collect, use, disclose and maintain protected personal information in order to provide services to these customers. HHS administers its audit program to assess HIPAA compliance efforts by covered entities and business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, including our Optum Labs business, we maintain a database of administrative and clinical data statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of protected personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business and, among other consequences, could subject us to mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents and material fines, penalties and litigation awards. Any of these consequences could have a material and adverse effect on our results of operations, financial position and cash flows.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our results of operations, financial position and cash flows.

Because we operate as a holding company, we are dependent on dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by state departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily on the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries exceeding specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flows could be materially and adversely affected.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions “Legal Matters” and “Governmental Investigations, Audits and Reviews” in Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements.”

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 29, 2021, there were 11,085 registered holders of record of our common stock.

DIVIDEND POLICY

In June 2020, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of $5.00 compared to $4.32 per share, which the Company had paid since June 2019. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

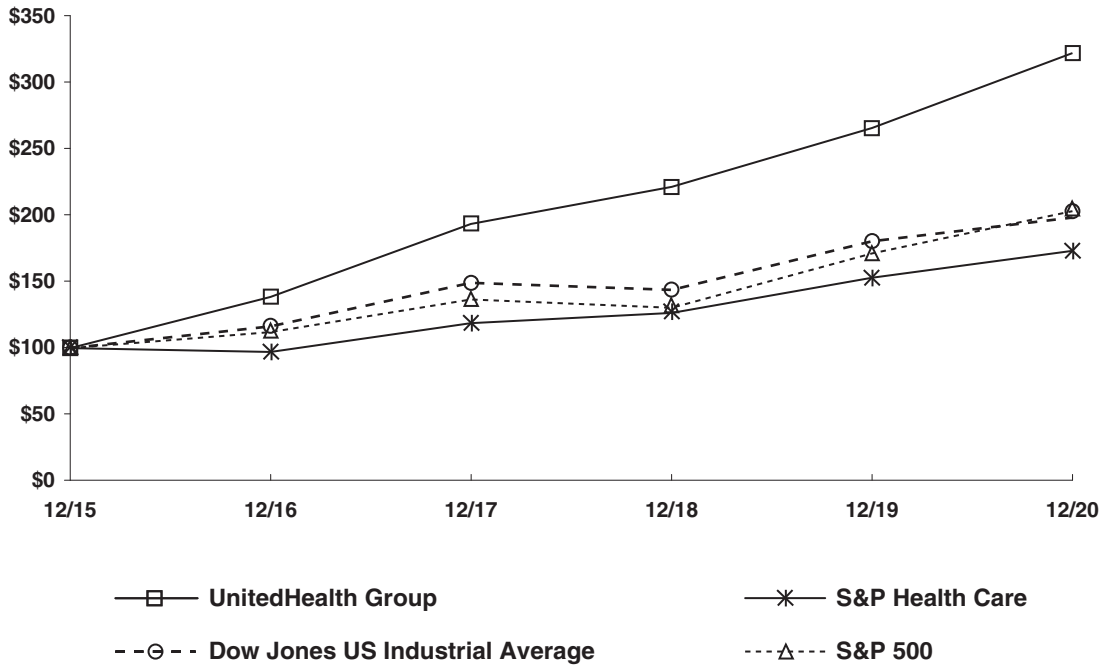
In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During the fourth quarter of 2020, we repurchased 5.1 million shares at an average price of $334.54 per share. As of December 31, 2020, we had Board authorization to purchase up to 58 million shares of our common stock.

PERFORMANCE GRAPH

The following performance graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P Health Care Index, the Dow Jones US Industrial Average Index and the S&P 500 index for the five-year period ended December 31, 2020. The comparisons assume the investment of $100 on December 31, 2015 in our common stock and in each index, and dividends were reinvested when paid.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P Health Care Index, the Dow Jones US Industrial Average Index and the S&P 500 Index



	12/15	12/16	12/17	12/18	12/19	12/20
UnitedHealth Group	**$100.00**	**$138.41**	**$193.52**	**$221.63**	**$265.92**	**$322.31**
S&P Health Care Index	**100.00**	**97.31**	**118.79**	**126.47**	**152.81**	**173.36**
Dow Jones US Industrial Average	**100.00**	**116.50**	**149.24**	**144.05**	**180.56**	**198.11**
S&P 500 Index	**100.00**	**111.96**	**136.40**	**130.42**	**171.49**	**203.04**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

Not applicable.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Part II Item 8, "Financial Statements." Readers are cautioned the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties which may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

Discussions of year-over-year comparisons between 2019 and 2018 are not included in this Form 10-K and can be found in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" of the Company's Form 10-K for the fiscal year ended December 31, 2019.

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health care company with a mission to help people live healthier lives and help make the health system work better for everyone. Our two complementary businesses—Optum and UnitedHealthcare—are driven by this unified mission and vision to improve health care access, affordability, experiences and outcomes for the individuals and organizations we are privileged to serve.

We have four reportable segments across our two business platforms, Optum and UnitedHealthcare:

- OptumHealth;
- OptumInsight;
- OptumRx; and
- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 14 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

COVID-19 Trends and Uncertainties

The COVID-19 pandemic continues to evolve and the ultimate impact on our business, results of operations, financial condition and cash flows remains uncertain. During the second quarter, the global health system experienced unprecedented levels of care deferral, which impacted all of our businesses. As the pandemic advanced, access to and demand for care was most constrained from mid-March through April, began to recover in May and June and restored to near normal seasonal levels in the third quarter. Care patterns continued to normalize in the fourth quarter, returning to, and even exceeding, seasonal baselines, including COVID-19 treatment and testing costs, towards the end of the quarter. The temporary deferral of care experienced in 2020 may cause care patterns to moderately exceed normal baselines in future periods as utilization of health system capacity continues to increase. From time to time, health system capacity may be subject to possible increased volatility due to the pandemic. Specific trends and uncertainties related to our two business platforms are as follows:

Optum. The temporary deferral of care impacted the Optum businesses for the year ended December 31, 2020. For example, our fee-for-service care delivery business, such as traditional procedure work at our ambulatory surgery centers, was negatively impacted, while our risk-based care delivery business performance reflected lower demand for care. Our OptumInsight and OptumRx volume-based businesses were negatively impacted by the lower level of care encounters which took place, as well as by broader economic factors, contributing to lower managed services and prescription volume. As the health system returned to normal seasonally adjusted levels of care, we have seen business activity approach normal levels. COVID-19 will also continue to influence customer and consumer behavior, both during and after the pandemic, which could impact how care is delivered and the manner in which consumers wish to receive their prescription drugs or infusion services. The impact of COVID-19 on our care provider and payer clients could impact the volume and types of services Optum provides, as well as the pacing of potential new business opportunities. As a result of the dynamic situation and broad-reaching impact to the health system, the ultimate impact of COVID-19 on our Optum businesses is uncertain.

UnitedHealthcare. During 2020, we expanded benefit coverage in areas such as COVID-19 care and testing, telemedicine, and pharmacy benefits; provided customers assistance in the form of co-pay waivers and premium forgiveness; offered additional enrollment opportunities to those who previously declined employer-sponsored offerings; extended certain premium payment terms for customers experiencing financial hardship; simplified administrative practices; and accelerated payments to care providers, all with the aim of assisting our customers, care providers, members and communities in addressing the COVID-19 crisis. Temporary care deferrals significantly impacted UnitedHealthcare's results of operations for the year ended December 31, 2020. The impact of temporary care deferrals was offset by COVID-19 related care and testing, the significant financial assistance we provided our customers, rebate requirements and broader economic impacts. Enrollment in our commercial products declined primarily due to employer actions in response to the pandemic.

Increased consumer demand for care, potentially even higher acuity care, along with continued COVID-19 care and testing costs are expected to result in increased future medical costs. Disrupted care patterns, as a result of the pandemic, may temporarily affect the ability to obtain complete member health status information, impacting future revenue in businesses utilizing risk adjustment methodologies. The ultimate overall impact is uncertain and dependent on the future pacing and intensity of the pandemic, the duration of policies and initiatives to address COVID-19, and general economic uncertainty.

Business Trends

Our businesses participate in the United States, South America and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises 18% of gross domestic product (GDP). We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions, such as the economic impact of COVID-19, and regulatory changes, which could impact our results of operations, including our continued efforts to control health care costs.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs, including any potential impacts from COVID-19. We frequently evaluate and adjust our approach in each of the local markets we serve, considering relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum MLR thresholds. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in both the small group and large group segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs. The ACA had an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally

across the insurance industry for risk-based health insurance products. Pricing for contracts covering some portion of calendar year 2021 reflected the permanent repeal of the Health Insurance Industry Tax.

Medicare Advantage funding continues to be pressured, as discussed below in "Regulatory Trends and Uncertainties."

We expect Medicaid revenue growth due to anticipated changes in mix and increases in the number of people we serve; we also believe the payment rate environment creates the risk of continued downward pressure on Medicaid margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We continue to advocate for actuarially sound rates commensurate with our medical cost trends and we remain dedicated to partnering with those states who are committed to the long-term viability of their programs.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. COVID-19 care and testing costs and certain of our customer assistance initiatives have also impacted medical cost trends in the current year and may continue in future years. We endeavor to mitigate those increases by engaging physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high-quality, affordable care. The uncertain impact of COVID-19 may impact our ability to estimate medical costs payable, which could result in increased variability to medical cost reserve development in future periods.

Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality, improve the health of populations and reduce costs. We continue to see a greater number of people enrolled in plans with underlying performance-based care provider payment models rewarding high-quality, affordable care and foster collaboration. We work together with clinicians to leverage our data and analytics to provide the necessary information to close gaps in care and improve overall health outcomes for patients.

We are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2020, we served nearly 18 million people through some form of aligned contractual arrangement, including full-risk, shared-risk and bundled episode-of-care and performance incentive payment approaches.

This trend is creating needs for health management services which can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe provide growth opportunities for our Optum business platform.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to some of the key provisions of the ACA and other regulatory matters. For additional information regarding the ACA and regulatory trends and uncertainties, see Part I, Item 1 "Business—Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates. Final 2021 Medicare Advantage rates resulted in an increase in industry base rates of approximately 1.7%, short of the industry forward medical cost trend, creating continued pressure in the Medicare Advantage program.

The ongoing Medicare Advantage funding pressure places continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we have made to partially offset these rate pressures and reductions. In some years, these adjustments impact the

majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits and implement or increase the member premiums supplementing the monthly payments we receive from the government. Additionally, we decide annually on a county-by-county basis where we will offer Medicare Advantage plans.

Our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on our local plans' Star ratings. The level of Star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses.

ACA Tax. After a moratorium in 2019, the industry-wide amount of the Health Insurance Industry Tax for 2020, which was primarily borne by customers, was $15.5 billion, with our portion being approximately $3.0 billion. The return of the tax impacted year-over-year comparability of our financial statements, including revenues, operating costs, medical care ratio (MCR), operating cost ratio, effective tax rate and cash flows from operations. The Health Insurance Industry Tax was permanently repealed by Congress, effective January 1, 2021.

SELECTED OPERATING PERFORMANCE ITEMS

The following represents a summary of select 2020 year-over-year operating comparisons to 2019.

- Consolidated revenues increased by 6%, UnitedHealthcare revenues increased 4% and Optum revenues grew 21%.
- UnitedHealthcare served 420,000 fewer people domestically primarily due to increased unemployment and attrition in commercial group benefits, partially offset by growth in government programs.
- Earnings from operations increased by 14%, including increases of 20% at UnitedHealthcare and 7% at Optum.
- Diluted earnings per common share increased 12% to $16.03.
- Cash flows from operations were $22.2 billion, an increase of 20%.
- Return on equity was 24.9%.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31, 2020	2019	2018	Change 2020 vs. 2019	
Revenues:					
Premiums	$201,478	$189,699	$178,087	$11,779	6%
Products	34,145	31,597	29,601	2,548	8
Services	20,016	18,973	17,183	1,043	5
Investment and other income	1,502	1,886	1,376	(384)	(20)
Total revenues	257,141	242,155	226,247	14,986	6
Operating costs:					
Medical costs	159,396	156,440	145,403	2,956	2
Operating costs	41,704	35,193	34,074	6,511	19
Cost of products sold	30,745	28,117	26,998	2,628	9
Depreciation and amortization	2,891	2,720	2,428	171	6
Total operating costs	234,736	222,470	208,903	12,266	6
Earnings from operations	22,405	19,685	17,344	2,720	14
Interest expense	(1,663)	(1,704)	(1,400)	41	(2)
Earnings before income taxes	20,742	17,981	15,944	2,761	15
Provision for income taxes	(4,973)	(3,742)	(3,562)	(1,231)	33
Net earnings	15,769	14,239	12,382	1,530	11
Earnings attributable to noncontrolling interests	(366)	(400)	(396)	34	(9)
Net earnings attributable to UnitedHealth Group common shareholders	$ 15,403	$ 13,839	$ 11,986	$ 1,564	11%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 16.03	$ 14.33	$ 12.19	$ 1.70	12%
Medical care ratio (a)	79.1%	82.5%	81.6%	(3.4)%	
Operating cost ratio	16.2	14.5	15.1	1.7	
Operating margin	8.7	8.1	7.7	0.6	
Tax rate	24.0	20.8	22.3	3.2	
Net earnings margin (b)	6.0	5.7	5.3	0.3	
Return on equity (c)	24.9%	25.7%	24.4%	(0.8)%	

(a) Medical care ratio is calculated as medical costs divided by premium revenue.
(b) Net earnings margin attributable to UnitedHealth Group shareholders.
(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

2020 RESULTS OF OPERATIONS COMPARED TO 2019 RESULTS

Consolidated Financial Results

Revenue

The increases in revenue were primarily driven by the increase in the number of individuals served through Medicare Advantage and Medicaid; pricing trends; and organic and acquisition growth across the Optum business, primarily due to expansion in pharmacy care services and care delivery. The increases were partially

offset by decreased individuals served through our commercial and Global benefits businesses, certain voluntary customer assistance programs and rebate requirements. Revenues were also negatively impacted by decreases in our fee-for-service care delivery and other volume-based businesses, primarily as a result of the care deferral and economic impacts of COVID-19.

Medical Costs and MCR

Medical costs increased as a result of growth in people served through Medicare Advantage and Medicaid, medical cost trends and COVID-19 care and testing costs, partially offset by decreased people served in commercial and Global, modestly lower care patterns and increased prior year favorable development. The MCR decreased primarily due to the temporary deferral of care and the revenue effects of the return of the Health Insurance Industry Tax, partially offset by COVID-19 care and testing costs, rebate requirements and voluntary customer assistance measures.

Operating Cost Ratio

The operating cost ratio increased primarily due to the impact of the return of the Health Insurance Industry Tax, COVID-19 response efforts and business mix, partially offset by operating efficiency gains.

Income Tax Rate

Our effective tax rate increased primarily due to the impact of the return of the nondeductible Health Insurance Industry Tax.

Reportable Segments

See Note 14 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements” for more information on our segments. We utilize various metrics to evaluate and manage our reportable segments, including individuals served by UnitedHealthcare by major market segment and funding arrangement, people served by OptumHealth and adjusted scripts for OptumRx. These metrics are the main drivers of revenue, earnings and cash flows at each business. The metrics also allow management and investors to evaluate and understand business mix, customer penetration and pricing trends when comparing the metrics to revenue by segment.

The following table presents a summary of the reportable segment financial information:

(in millions, except percentages)	For the Years Ended December 31, 2020	2019	2018	Change 2020 vs. 2019	
Revenues					
UnitedHealthcare	$200,875	$193,842	$183,476	$ 7,033	4%
OptumHealth	39,808	30,317	24,145	9,491	31
OptumInsight	10,802	10,006	9,008	796	8
OptumRx	87,498	74,288	69,536	13,210	18
Optum eliminations	(1,800)	(1,661)	(1,409)	(139)	8
Optum	136,308	112,950	101,280	23,358	21
Eliminations	(80,042)	(64,637)	(58,509)	(15,405)	24
Consolidated revenues	$257,141	$242,155	$226,247	$ 14,986	6%
Earnings from operations					
UnitedHealthcare	$ 12,359	$ 10,326	$ 9,113	$ 2,033	20%
OptumHealth	3,434	2,963	2,430	471	16
OptumInsight	2,725	2,494	2,243	231	9
OptumRx	3,887	3,902	3,558	(15)	—
Optum	10,046	9,359	8,231	687	7
Consolidated earnings from operations	$ 22,405	$ 19,685	$ 17,344	$ 2,720	14%
Operating margin					
UnitedHealthcare	6.2%	5.3%	5.0%	0.9%	
OptumHealth	8.6	9.8	10.1	(1.2)	
OptumInsight	25.2	24.9	24.9	0.3	
OptumRx	4.4	5.3	5.1	(0.9)	
Optum	7.4	8.3	8.1	(0.9)	
Consolidated operating margin	8.7%	8.1%	7.7%	0.6%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	For the Years Ended December 31, 2020	2019	2018	Change 2020 vs. 2019	
UnitedHealthcare Employer & Individual	$ 55,872	$ 56,945	$ 54,761	$(1,073)	(2)%
UnitedHealthcare Medicare & Retirement	90,764	83,252	75,473	7,512	9
UnitedHealthcare Community & State	46,487	43,790	43,426	2,697	6
UnitedHealthcare Global	7,752	9,855	9,816	(2,103)	(21)
Total UnitedHealthcare revenues	$200,875	$193,842	$183,476	$ 7,033	4%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31, 2020	2019	2018	Change 2020 vs. 2019	
Commercial:					
Risk-based	7,910	8,575	8,495	(665)	(8)%
Fee-based	18,310	19,185	18,420	(875)	(5)
Total commercial	26,220	27,760	26,915	(1,540)	(6)
Medicare Advantage	5,710	5,270	4,945	440	8
Medicaid	6,620	5,900	6,450	720	12
Medicare Supplement (Standardized)	4,460	4,500	4,545	(40)	(1)
Total public and senior	16,790	15,670	15,940	1,120	7
Total UnitedHealthcare — domestic medical	43,010	43,430	42,855	(420)	(1)
Global	5,425	5,720	6,220	(295)	(5)
Total UnitedHealthcare — medical	48,435	49,150	49,075	(715)	(1)%
Supplemental Data:					
Medicare Part D stand-alone	4,045	4,405	4,710	(360)	(8)%

Fee-based and risk-based commercial business decreased primarily due to increased unemployment and related attrition. Medicare Advantage increased due to growth in people served through individual Medicare Advantage plans. The increase in people served through Medicaid was primarily driven by states easing redetermination requirements due to COVID-19 and growth in people served via Dual Special Needs Plans. The decrease in people served by UnitedHealthcare Global is a result of increased unemployment and underwriting discipline.

UnitedHealthcare's revenue increased due to growth in the number of individuals served through Medicare Advantage and Medicaid, a greater mix of people with higher acuity needs and the return of the Health Insurance Industry Tax, partially offset by a decrease in the number of individuals served through the commercial and Global businesses and foreign currency impacts. In 2020, earnings from operations increased due to the deferral of care caused by COVID-19 on the health system and the factors impacting revenue, partially offset by the return of the Health Insurance Industry Tax, COVID-19 care and testing costs, customer assistance programs and broader economic effects.

Optum

Total revenues increased as each segment reported revenue growth. Earnings from operations increased due to growth at OptumHealth and OptumInsight.

The results by segment were as follows:

OptumHealth

Revenue and earnings at OptumHealth increased primarily due to organic growth and acquisitions in risk-based care delivery. Reduced care volumes in fee-for-service arrangements as a result of COVID-19 partially offset the increases in revenues and earnings. OptumHealth served approximately 98 million people as of December 31, 2020 compared to 96 million people as of December 31, 2019.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to growth in technology and managed services, partially offset by decreased activity levels in volume-based services due to the impact of COVID-19 on payer and care provider clients.

OptumRx

Revenue at OptumRx and the corresponding eliminations increased due to the inclusion of retail pharmacy co-payments. See Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for further detail. Revenue at OptumRx also increased due to organic and acquisition growth in pharmacy care services, including specialty pharmacy, and new client wins, partially offset by an expected large client transition and lower script volumes driven by COVID-19 related care deferral and fewer people served due to economic-driven employment attrition. Earnings from operations remained relatively flat as COVID-19 impacts were partially offset by the factors impacting revenue and improved supply chain management. OptumRx fulfilled 1.3 billion adjusted scripts in both 2020 and 2019 with growth offset by the large client transition.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to, among other things, minimal levels of statutory capital, as defined by their respective jurisdiction, and restrictions on the timing and amount of dividends paid to their parent companies.

Our U.S. regulated subsidiaries paid their parent companies dividends of $8.3 billion and $5.6 billion in 2020 and 2019, respectively. See Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for further detail concerning our regulated subsidiary dividends.

Our nonregulated businesses also generate significant cash flows from operations available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt and return capital to our shareholders through dividends and repurchases of our common stock.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	For the Years Ended December 31, 2020	2019	2018	Change 2020 vs. 2019
Sources of cash:				
Cash provided by operating activities	$ 22,174	$ 18,463	$ 15,713	$ 3,711
Issuances of long-term debt and short-term borrowings, net of repayments	2,586	3,994	4,134	(1,408)
Proceeds from common share issuances	1,440	1,037	838	403
Customer funds administered	1,677	13	—	1,664
Other	—	219	—	(219)
Total sources of cash	27,877	23,726	20,685	
Uses of cash:				
Cash paid for acquisitions, net of cash assumed	(7,139)	(8,343)	(5,997)	1,204
Cash dividends paid	(4,584)	(3,932)	(3,320)	(652)
Common share repurchases	(4,250)	(5,500)	(4,500)	1,250
Purchases of property, equipment and capitalized software	(2,051)	(2,071)	(2,063)	20
Purchases of investments, net of sales and maturities	(2,836)	(2,504)	(4,099)	(332)
Other	(965)	(1,237)	(1,743)	272
Total uses of cash	(21,825)	(23,587)	(21,722)	
Effect of exchange rate changes on cash and cash equivalents	(116)	(20)	(78)	(96)
Net increase (decrease) in cash and cash equivalents	$ 5,936	$ 119	$ (1,115)	$ 5,817

2020 Cash Flows Compared to 2019 Cash Flows

Increased cash flows provided by operating activities were primarily driven by higher net earnings as well as changes in working capital accounts. Other significant changes in sources or uses of cash year-over-year included an increase in customer funds administered and net purchases of investments, and decreases in net issuances of long-term debt and short-term borrowings, cash paid for acquisitions and share repurchases.

Financial Condition

As of December 31, 2020, our cash, cash equivalent, available-for-sale debt securities and equity securities balances of $59.0 billion included $16.9 billion of cash and cash equivalents (of which $1.3 billion was available for general corporate use), $39.8 billion of debt securities and $2.3 billion of equity securities. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is fully supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements” for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 3.7 years and a weighted-average credit rating of “Double A” as of December 31, 2020. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

Cash Requirements. The Company's cash requirements within the next twelve months include medical costs payable, accounts payable and accrued liabilities, commercial paper and current maturities of long-term debt, other current liabilities, and purchase commitments and other obligations. We expect the cash required to meet these obligations to be primarily generated through cash flows from current operations; cash available for general corporate use; and the realization of current assets, such as accounts receivable.

Our long-term cash requirements under our various contractual obligations and commitments include:

- *Debt Obligations.* See Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for further detail of our commercial paper and long-term debt and the timing of expected future payments. Interest coupon payments are typically paid semi-annually.
- *Operating leases*. See Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for further detail of our obligations and the timing of expected future payments.
- *Purchase and other obligations.* These include $5.3 billion, $2.0 billion of which is expected to be paid within the next twelve months, of fixed or minimum commitments under existing purchase obligations for goods and services, including agreements cancelable with the payment of an early termination penalty, and remaining capital commitments for venture capital funds and other funding commitments. These amounts exclude agreements cancelable without penalty and liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2020.
- *Other Liabilities.* These include other long-term liabilities reflected in our Consolidated Balance Sheets as of December 31, 2020, including obligations associated with certain employee benefit programs, unrecognized tax benefits and various long-term liabilities, which have some inherent uncertainty in the timing of these payments.
- *Redeemable noncontrolling interests.* See Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for further detail. We do not have any material required redemptions in the next twelve months.

We expect the cash required to meet our long-term obligations to be primarily generated through future cash flows from operations. However, we also have the ability to generate cash to satisfy both our current and long-term requirements through the issuance of commercial paper, issuance of long-term debt, or drawing under our committed credit facilities or the ability to sell investments. We believe our capital resources are sufficient to meet future, short-term and long-term, liquidity needs.

Short-Term Borrowings. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of senior unsecured debt through independent broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 60%, subject to increase in certain circumstances set forth in the applicable credit agreement. As of December 31, 2020, our debt to debt-plus-shareholders' equity ratio, as defined and calculated under the credit facilities, was 38%.

Long-Term Debt. Periodically, we access capital markets to issue long-term debt for general corporate purposes, such as, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases. For more information on our debt, see Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8 "Financial Statements."

Credit Ratings. Our credit ratings as of December 31, 2020 were as follows:

	Moody's		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A+	Stable	A	Stable	A-	Positive
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-1	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. A significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. As of December 31, 2020, we had Board authorization to purchase up to 58 million shares of our common stock. For more information on our share repurchase program, see Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Dividends. In June 2020, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of $5.00 compared to $4.32 per share, which the Company had paid since June 2019. For more information on our dividend, see Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Pending Acquisitions. In the fourth quarter of 2020, we entered into agreements to acquire multiple companies in the health care sector, which are expected to close in the first half of 2021, subject to regulatory approval and other customary closing conditions. Additionally, in January 2021, we entered into agreements to purchase multiple companies in the health care sector, most notably, Change Healthcare (NASDAQ: CHNG). This acquisition is expected to close in the second half of 2021, subject to Change Healthcare shareholders' approval, regulatory approvals and other customary closing conditions. The total anticipated capital required for these acquisitions, excluding the payoff of acquired indebtedness, is approximately $13 billion.

We do not have other significant contractual obligations or commitments requiring cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications and may include acquisitions.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 2 of the Notes to the Consolidated Financial Statements in Part II, Item 8 "Financial Statements" for a discussion of new accounting pronouncements which affect us.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates requiring management to make challenging, subjective or complex judgments, often because they must estimate the effects of matters inherently uncertain and may change in subsequent periods. Critical accounting estimates involve judgments and uncertainties which are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

Medical costs and medical costs payable include estimates of our obligations for medical care services rendered on behalf of insured consumers, but for which claims have either not yet been received or processed. Depending on the health care professional and type of service, the typical billing lag for services can be up to 90 days from the date of service. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months. As of December 31, 2020, our days outstanding in medical payables was 48 days, calculated as total medical payables divided by total medical costs times the number of days in the period.

In each reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods. If the revised estimate of prior period medical costs is less than the previous estimate, we will decrease reported medical costs in the current period (favorable development). If the revised estimate of prior period medical costs is more than the previous estimate, we will increase reported medical costs in the current period (unfavorable development). Medical costs in 2020, 2019 and 2018 included favorable medical cost development related to prior years of $880 million, $580 million and $320 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, for the most recent two months, we estimate claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period adjudicated by us at the date of estimation. Completion factors are the most significant factors we use in developing our medical costs payable estimates for periods prior to the most recent two months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim levels and processing cycles, as well as other factors. Our judgments also consider the impacts of COVID-19 on these factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserve estimates may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2020:

Completion Factors (Decrease) Increase in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 600
(0.50)	399
(0.25)	199
0.25	(198)
0.50	(395)
0.75	(591)

Medical Cost Per Member Per Month Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent two months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design and a review of a broad set of health care utilization indicators, which included consideration of COVID-19 in 2020. These factors include but are not limited to pharmacy utilization trends, inpatient hospital authorization data and influenza incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as GDP growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates, including: our ability and practices to manage medical and pharmaceutical costs, changes in level and mix of services utilized, mix of benefits offered, including the impact of co-pays and deductibles, changes in medical practices, catastrophes, epidemics and pandemics, such as COVID-19.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent two months as of December 31, 2020:

Medical Cost PMPM Quarterly Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 793
2	529
1	264
(1)	(264)
(2)	(529)
(3)	(793)

The completion factors and medical costs PMPM trend factors analyses above include outcomes considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2020; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2020 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2020 net earnings would have increased or decreased by approximately $157 million.

For more detail related to our medical cost estimates, see Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements.”

Goodwill

We evaluate goodwill for impairment annually or more frequently when an event occurs or circumstances change indicating the carrying value may not be recoverable. When testing goodwill for impairment, we may first assess qualitative factors to determine if it is more likely than not the carrying value of a reporting unit exceeds its estimated fair value. During a qualitative analysis, we consider the impact of changes, if any, to the following factors: macroeconomic, industry and market factors, cost factors, changes in overall financial performance, and any other relevant events and uncertainties impacting a reporting unit. If our qualitative assessment indicates a goodwill impairment is more likely than not, we perform additional quantitative analyses. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing. For reporting units where a quantitative analysis is performed, we perform a test measuring the fair values of the reporting units and comparing them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, an impairment is recognized for the difference, up to the carrying amount of goodwill.

We estimate the fair values of our reporting units using a discounted cash flow method or a weighted combination of discounted cash flows and a market-based method. The discounted cash flow method includes assumptions about a wide variety of internal and external factors. Significant assumptions used in the discounted cash flow method include financial projections of free cash flow, including revenue trends, medical costs trends, operating productivity, income taxes and capital levels; long-term growth rates for determining terminal value beyond the discretely forecasted periods; and discount rates. Financial projections and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. Our most significant estimate in the discount rate determinations involves our adjustments to the peer company weighted average costs of capital reflecting reporting unit-specific factors.

We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty. The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units' operations could cause these assumptions to change in the future. Additionally, as part of our quantitative impairment testing, we perform various sensitivity analyses on certain key assumptions, such as discount rates, cash flow projections and peer company multiples to analyze the potential for a material impact. The market-based method requires determination of appropriate peer group whose securities are traded on an active market. The peer group is used to derive market multiples to estimate fair value. As of October 1, 2020, we completed our annual impairment tests for goodwill with all of our reporting units having fair values substantially in excess of their carrying values.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our Board of Directors. This policy limits the amounts which may be invested in any one issuer and generally limits our investments to U.S. government and agency securities, state and municipal securities and corporate debt obligations of investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups and other customers constituting our client base. As of December 31, 2020, there were no significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to changes in interest rates impacting our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, as well as foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real and Chilean peso.

As of December 31, 2020, we had $20 billion of financial assets on which the interest rates received vary with market interest rates, which may significantly impact our investment income. Also as of December 31, 2020, $8 billion of our financial liabilities, which include commercial paper, debt and deposit liabilities, were at interest rates which vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2020, $37 billion of our investments were fixed-rate debt securities and $45 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed-income market sectors and debt across maturities, as well as by matching a portion of our floating-rate assets and liabilities, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale debt securities are reported in comprehensive income.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of December 31, 2020 and 2019 on our investment income and interest expense per annum and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2020			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets	Fair Value of Financial Liabilities
2%	$ 401	$ 163	$ (3,020)	$ (8,700)
1	201	82	(1,499)	(4,744)
(1)	(75)	(12)	820	5,266
(2)	(75)	(12)	886	8,101

	December 31, 2019			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets	Fair Value of Financial Liabilities
2%	$ 282	$ 185	$ (2,668)	$ (6,813)
1	141	93	(1,331)	(3,704)
(1)	(141)	(93)	1,246	4,433
(2)	(282)	(185)	2,071	9,613

Note: Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2020, the assumed hypothetical change in interest rates does not reflect the full 100 and 200 basis point reduction in interest income or interest expense, as the rates are assumed not to fall below zero. As of December 31, 2020 and 2019, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

We have an exposure to changes in the value of foreign currencies, primarily the Brazilian real and the Chilean peso, to the U.S. dollar in translation of UnitedHealthcare Global's operating results at the average exchange rate over the accounting period, and UnitedHealthcare Global's assets and liabilities at the exchange rate at the end of the accounting period. The gains or losses resulting from translating foreign assets and liabilities into U.S. dollars are included in equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real or Chilean peso reduces the carrying value of the net assets denominated in those currencies. For example, as of December 31, 2020, a hypothetical 10% and 25% increase in the value of the U.S. dollar against those currencies would have caused a reduction in net assets of approximately $535 million and $1.2 billion, respectively. We manage exposure to foreign currency earnings risk primarily by conducting our international business operations in their functional currencies.

As of December 31, 2020, we had $2.3 billion of investments in equity securities, primarily consisting of investments in employee savings plan related investments and non-U.S. dollar fixed-income funds. Valuations in non-U.S. dollar funds are subject to foreign exchange rates.

ITEM 8. FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2020 and 2019, the related consolidated statements of operations, comprehensive income, changes in equity and cash flows for each of the three years in the period ended December 31, 2020, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2020 and 2019, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2020, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2020, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated March 1, 2021 expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current-period audit of the financial statements that were communicated or required to be communicated to the audit committee and that (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Incurred but not Reported (IBNR) Claim Liability—Refer to Notes 2 and 7 to the financial statements.

Critical Audit Matter Description

Medical costs payable includes estimates of the Company's obligations for medical care services rendered on behalf of insured consumers, for which claims have either not yet been received or processed. These estimates

are referred to as incurred but not reported (IBNR) claim liabilities. The Company develops IBNR estimates using an actuarial model that requires management to exercise certain judgments in developing its estimates. Judgments made by management include medical cost per member per month trend factors and completion factors, which include assumptions over the time from date of service to claim receipt, the impact of claim levels, and processing cycles.

We identified the IBNR claim liability as a critical audit matter because of the significant assumptions made by management in estimating the liability. This required complex auditor judgment, and an increased extent of effort, including the involvement of actuarial specialists in performing procedures to evaluate the reasonableness of management's methods, assumptions and judgments in developing the liability.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures included the following, among others:

- We tested the effectiveness of controls over management's estimate of the IBNR claim liability balance, including controls over the judgments in both the completion factors and the medical cost per member per month trend factors.
- We tested the underlying claims and membership data and other information that served as the basis for the actuarial analysis, to test that the inputs to the actuarial estimate were complete and accurate.
- With the assistance of actuarial specialists, we evaluated the reasonableness of the actuarial methods and assumptions used by management to estimate the IBNR claim liability by:
    - Performing an overlay of the historical claims data used in management's current year model to the data used in prior periods to validate that there were no material changes to the claims data tested in prior periods.
    - Developing an independent estimate of the IBNR claim liability and comparing our estimate to management's estimate.
    - Performing a retrospective review comparing management's prior year estimate of IBNR to claims processed in 2020 with dates of service in 2019 or prior.

Goodwill—Refer to Notes 2 and 6 to the financial statements.

Critical Audit Matter Description

At December 31, 2020, the Company's goodwill balance was $71 billion. As discussed in Note 2 of the financial statements, for reporting units where a quantitative analysis is performed, the Company performs an annual impairment test measuring the fair values of the reporting units and comparing them to their aggregate carrying values including goodwill. The estimates of the reporting unit fair values are calculated using a discounted cash flow method or a weighted combination of discounted cash flows and a market-based method. The discounted cash flow method includes assumptions about revenue trends, medical cost trends, and operating costs as well as discount rates. The market-based method requires determination of an appropriate group of peer companies whose securities are traded on an active market. The fair values of the reporting units exceeded the carrying values as of the impairment testing date, therefore no impairment was recognized.

We identified a critical audit matter related to the quantitative analysis performed for such reporting units because of the significant assumptions made by management to estimate the fair value of the reporting unit. This required increased auditor judgment and extent of effort, including involvement of fair value specialists to evaluate the reasonableness of management's estimates and assumptions related to peer company selection and financial projections, which can be impacted by regulatory and macro-economic factors.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures related to the valuation, business, and market assumptions including the discount rate, financial forecasts, and peer group used by management to estimate the fair value of reporting units where a quantitative analysis was performed, included the following, among others:

- We tested the effectiveness of controls over management's annual goodwill impairment assessment, including those over the determination of the fair value such as controls related to management's financial forecasts, as well as controls over the selection of discount rates, company specific risks, peer companies, and market multiples.
- We evaluated management's ability to forecast and meet future revenue, medical cost trend, and operating costs by comparing:
    - Actual results to historical forecasts.
    - Forecasted information to: internal communications to management and the Board of Directors, industry and economic trends, and analyst reports of revenue and earnings expectations for the Company and its peers.
- We evaluated the impact of changes in management's forecasts from the October 1, 2020 annual measurement date to December 31, 2020.
- We evaluated management's selection of peer companies and market multiples.
- With the assistance of our fair value specialists, we evaluated the reasonableness of the (1) valuation methodologies, including testing the mathematical accuracy of the calculation, (2) the weighting of such valuation methodologies, and (3) discount rate and company specific risks by:
    - Testing the source information underlying the determination of the discount rate and the mathematical accuracy of the calculation.
    - Developing a range of independent discount rate estimates and comparing to those selected by management.

/S/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
March 1, 2021

We have served as the Company's auditor since 2002.

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2020	December 31, 2019
Assets		
Current assets:		
Cash and cash equivalents	$ 16,921	$ 10,985
Short-term investments	2,860	3,260
Accounts receivable, net of allowances of $990 and $519	12,870	11,822
Other current receivables, net of allowances of $1,047 and $859	12,534	9,640
Assets under management	4,076	3,076
Prepaid expenses and other current assets	4,457	3,851
Total current assets	53,718	42,634
Long-term investments	41,242	37,209
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $5,230 and $4,995	8,626	8,704
Goodwill	71,337	65,659
Other intangible assets, net of accumulated amortization of $5,455 and $5,072	10,856	10,349
Other assets	11,510	9,334
Total assets	$ 197,289	$ 173,889
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	$ 21,872	$ 21,690
Accounts payable and accrued liabilities	22,495	19,005
Short-term borrowings and current maturities of long-term debt	4,819	3,870
Unearned revenues	2,842	2,622
Other current liabilities	20,392	14,595
Total current liabilities	72,420	61,782
Long-term debt, less current maturities	38,648	36,808
Deferred income taxes	3,367	2,993
Other liabilities	12,315	10,144
Total liabilities	126,750	111,727
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	2,211	1,726
Equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 946 and 948 issued and outstanding	10	9
Additional paid-in capital	—	7
Retained earnings	69,295	61,178
Accumulated other comprehensive loss	(3,814)	(3,578)
Nonredeemable noncontrolling interests	2,837	2,820
Total equity	68,328	60,436
Total liabilities, redeemable noncontrolling interests and equity	$ 197,289	$ 173,889

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2020	2019	2018
Revenues:			
Premiums	$201,478	$189,699	$178,087
Products	34,145	31,597	29,601
Services	20,016	18,973	17,183
Investment and other income	1,502	1,886	1,376
Total revenues	257,141	242,155	226,247
Operating costs:			
Medical costs	159,396	156,440	145,403
Operating costs	41,704	35,193	34,074
Cost of products sold	30,745	28,117	26,998
Depreciation and amortization	2,891	2,720	2,428
Total operating costs	234,736	222,470	208,903
Earnings from operations	22,405	19,685	17,344
Interest expense	(1,663)	(1,704)	(1,400)
Earnings before income taxes	20,742	17,981	15,944
Provision for income taxes	(4,973)	(3,742)	(3,562)
Net earnings	15,769	14,239	12,382
Earnings attributable to noncontrolling interests	(366)	(400)	(396)
Net earnings attributable to UnitedHealth Group common shareholders	$ 15,403	$ 13,839	$ 11,986
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$ 16.23	$ 14.55	$ 12.45
Diluted	$ 16.03	$ 14.33	$ 12.19
Basic weighted-average number of common shares outstanding	949	951	963
Dilutive effect of common share equivalents	12	15	20
Diluted weighted-average number of common shares outstanding	961	966	983
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	8	10	6

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2020	2019	2018
Net earnings	$15,769	$14,239	$12,382
Other comprehensive (loss) income:			
Gross unrealized gains (losses) on investment securities during the period	1,058	1,212	(294)
Income tax effect	(253)	(279)	67
Total unrealized gains (losses), net of tax	805	933	(227)
Gross reclassification adjustment for net realized gains included in net earnings	(75)	(104)	(62)
Income tax effect	17	24	14
Total reclassification adjustment, net of tax	(58)	(80)	(48)
Total foreign currency translation losses	(983)	(271)	(1,242)
Other comprehensive (loss) income	(236)	582	(1,517)
Comprehensive income	15,533	14,821	10,865
Comprehensive income attributable to noncontrolling interests	(366)	(400)	(396)
Comprehensive income attributable to UnitedHealth Group common shareholders	$15,167	$14,421	$10,469

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income: Net Unrealized (Losses) Gains on Investments	Accumulated Other Comprehensive (Loss) Income: Foreign Currency Translation Losses	Nonredeemable Noncontrolling Interests	Total Equity
Balance at January 1, 2018	969	$ 10	$ 1,703	$ 48,730	$ (13)	$ (2,654)	$ 2,057	$ 49,833
Adjustment to adopt ASU 2016-01				(24)	24			—
Net earnings				11,986			273	12,259
Other comprehensive loss					(275)	(1,242)		(1,517)
Issuances of common stock, and related tax effects	10	—	814					814
Share-based compensation			620					620
Common share repurchases	(19)	—	(2,974)	(1,526)				(4,500)
Cash dividends paid on common shares ($3.45 per share)				(3,320)				(3,320)
Redeemable noncontrolling interest fair value and other adjustments			(163)					(163)
Acquisition and other adjustments of nonredeemable noncontrolling interests							521	521
Distributions to nonredeemable noncontrolling interest							(228)	(228)
Balance at December 31, 2018	960	10	—	55,846	(264)	(3,896)	2,623	54,319
Adjustment to adopt ASU 2016-02				(13)			(5)	(18)
Net earnings				13,839			285	14,124
Other comprehensive income (loss)					853	(271)		582
Issuances of common stock, and related tax effects	10	—	696					696
Share-based compensation			673					673
Common share repurchases	(22)	(1)	(937)	(4,562)				(5,500)
Cash dividends paid on common shares ($4.14 per share)				(3,932)				(3,932)
Redeemable noncontrolling interest fair value and other adjustments			(316)					(316)
Acquisition and other adjustments of nonredeemable noncontrolling interests			(109)				196	87
Distributions to nonredeemable noncontrolling interest							(279)	(279)
Balance at December 31, 2019	948	9	7	61,178	589	(4,167)	2,820	60,436
Adjustment to adopt ASU 2016-13				(28)				(28)
Net earnings				15,403			254	15,657
Other comprehensive income (loss)					747	(983)		(236)
Issuances of common stock, and related tax effects	12	1	1,119					1,120
Share-based compensation			647					647
Common share repurchases	(14)	—	(1,576)	(2,674)				(4,250)
Cash dividends paid on common shares ($4.83 per share)				(4,584)				(4,584)
Redeemable noncontrolling interests fair value and other adjustments			(197)					(197)
Acquisition and other adjustments of nonredeemable noncontrolling interests							40	40
Distributions to nonredeemable noncontrolling interests							(277)	(277)
Balance at December 31, 2020	946	$ 10	$ —	$ 69,295	$ 1,336	$ (5,150)	$ 2,837	$ 68,328

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2020	2019	2018
Operating activities			
Net earnings	$ 15,769	$ 14,239	$ 12,382
Noncash items:			
Depreciation and amortization	2,891	2,720	2,428
Deferred income taxes	(8)	230	42
Share-based compensation	679	697	638
Other, net	(52)	(106)	(71)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(688)	162	(1,351)
Other assets	(2,195)	(1,563)	(750)
Medical costs payable	152	1,221	1,831
Accounts payable and other liabilities	5,348	733	526
Unearned revenues	278	130	38
Cash flows from operating activities	22,174	18,463	15,713
Investing activities			
Purchases of investments	(16,577)	(18,131)	(14,010)
Sales of investments	6,489	8,536	3,641
Maturities of investments	7,252	7,091	6,270
Cash paid for acquisitions, net of cash assumed	(7,139)	(8,343)	(5,997)
Purchases of property, equipment and capitalized software	(2,051)	(2,071)	(2,063)
Other, net	(506)	219	(226)
Cash flows used for investing activities	(12,532)	(12,699)	(12,385)
Financing activities			
Common share repurchases	(4,250)	(5,500)	(4,500)
Cash dividends paid	(4,584)	(3,932)	(3,320)
Proceeds from common stock issuances	1,440	1,037	838
Repayments of long-term debt	(3,150)	(1,750)	(2,600)
Proceeds from (repayments of) short-term borrowings, net	872	300	(201)
Proceeds from issuance of long-term debt	4,864	5,444	6,935
Customer funds administered	1,677	13	(131)
Other, net	(459)	(1,237)	(1,386)
Cash flows used for financing activities	(3,590)	(5,625)	(4,365)
Effect of exchange rate changes on cash and cash equivalents	(116)	(20)	(78)
Increase (decrease) in cash and cash equivalents	5,936	119	(1,115)
Cash and cash equivalents, beginning of period	10,985	10,866	11,981
Cash and cash equivalents, end of period	$ 16,921	$ 10,985	$ 10,866
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,704	$ 1,627	$ 1,410
Cash paid for income taxes	4,935	3,542	3,257

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and "the Company") is a diversified health care company with a mission to help people live healthier lives and help make the health system work better for everyone. Our two complementary businesses—Optum and UnitedHealthcare—are driven by this unified mission and vision to improve health care access, affordability, experiences and outcomes for the individuals and organizations we are privileged to serve.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to estimates and judgments for medical costs payable and goodwill. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premiums

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company's customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios (MLRs) as calculated under the definitions in the Patient Protection and Affordable Care Act (ACA) and related federal and state regulations and implementing regulation, falling below certain targets are required to rebate ratable portions of their premiums annually. Commercial premiums within the Company's individual and small group markets are also subject to the ACA risk adjustment program. Medicare Advantage premium revenue includes the impact of the Centers for Medicare & Medicaid Services (CMS) quality bonuses based on plans' Star rating. Certain of the Company's Medicaid business is also subject to state minimum MLR rebates.

Premium revenues are recognized based on the estimated premiums earned, net of projected rebates, because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues for certain risk-based arrangements at its OptumHealth care delivery businesses.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under CMS' risk adjustment payment methodology. CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk

adjusted premium payment using diagnosis and encounter data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture and submit the necessary and available data to CMS within prescribed deadlines. The Company estimates risk adjustment premium revenues based upon the data submitted and expected to be submitted to CMS. Risk adjustment data for the Company's plans are subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Products and Services

For the Company's OptumRx pharmacy care services business, the majority of revenues are derived from products sold through a contracted network of retail pharmacies or home delivery, specialty and community health pharmacies. Product revenues include the cost of pharmaceuticals (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's home delivery, specialty and community pharmacies. For the year ended December 31, 2020, the Company recognized revenue and cost of products sold for retail pharmacy co-payments related to its OptumRx business. Revenue recognized in prior periods related to retail pharmacy transactions excludes the member's applicable co-payment. There was no impact on earnings from operations, net earnings, earnings per share or total equity. Pharmacy products are billed to customers based on the number of transactions occurring during the billing period. Product revenues are recognized when the prescriptions are dispensed. The Company has entered into contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless of whether the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members and accordingly, are reported on a gross basis.

Services revenue consists of fees derived from services performed for customers who self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company receives monthly, a fixed fee per employee, which is recognized as revenue as the Company performs, or makes available, the applicable services to the customer. The customers retain the risk of financing health care costs for their employees and employees' dependents, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements. For these fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

Revenues are also comprised of a number of services and products sold through Optum. OptumHealth's service revenues include net patient service revenues recorded based upon established billing rates, less allowances for contractual adjustments, and are recognized as services are provided. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds. OptumInsight provides software and information products, advisory consulting arrangements and managed services outsourcing contracts, which may be delivered over several years. OptumInsight revenues are generally recognized over time and measured each period based on the progress to date as services are performed or made available to customers.

As of December 31, 2020 and 2019, accounts receivables related to products and services were $5.3 billion and $4.3 billion, respectively. In 2020 and 2019, the Company had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the Consolidated Balance Sheets as of December 31, 2020 or 2019.

For the years ended December 31, 2020 and 2019, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price) was not material.

Revenue expected to be recognized in any future year related to remaining performance obligations, excluding revenue pertaining to contracts having an original expected duration of one year or less, contracts where revenue is recognized as invoiced and contracts with variable consideration related to undelivered performance obligations, is not material.

See Note 14 for disaggregation of revenue by segment and type.

Medical Costs and Medical Costs Payable

The Company's estimate of medical costs payable represents management's best estimate of its liability for unpaid medical costs as of December 31, 2020.

Each period, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months.

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services rendered on behalf of insured consumers, but for which claims have either not yet been received, processed, or paid. The Company develops estimates for medical care services incurred but not reported (IBNR), which includes estimates for claims which have not been received or fully processed, using an actuarial process consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim processing, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography. Judgments related to these factors contemplated the impact of COVID-19 in 2020.

In developing its medical costs payable estimates, the Company applies different estimation methods depending on which incurred claims are being estimated. For the most recent two months, the Company estimates claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data are available, supplemented by a review of near-term completion factors (actuarial estimates, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period adjudicated by the Company at the date of estimation). For months prior to the most recent two months, the Company applies the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months.

Cost of Products Sold

The Company's cost of products sold includes the cost of pharmaceuticals dispensed to unaffiliated customers either directly at its home delivery, specialty and community pharmacy locations, or indirectly through its nationwide network of participating pharmacies. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold, with a corresponding payable for the amounts of the rebates to be remitted to those non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. Cost of products sold also includes the cost of personnel to support the Company's transaction processing services, system sales, maintenance and professional services.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments having an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available. Equity investments, with certain exceptions, are measured at fair value with changes in fair value recognized in net earnings.

The Company excludes unrealized gains and losses on investments in available-for-sale debt securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of equity. To calculate realized gains and losses on the sale of debt securities, the Company specifically identifies the cost of each investment sold.

The Company evaluates an available-for-sale debt security for credit-related impairment by considering the present value of expected cash flows relative to a security's amortized cost, the extent to which fair value is less than amortized cost, the financial condition and near-term prospects of the issuer and specific events or circumstances which may influence the operations of the issuer. Credit-related impairments are recorded as an allowance, with an offset to investment and other income. Non-credit related impairments are recorded through other comprehensive income. If the Company intends to sell an impaired security, or will likely be required to sell a security before recovery of the entire amortized cost, the entire impairment is included in net earnings.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the Company's investment policy.

Assets Under Management

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the AARP Program) and to AARP members and non-members under separate Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP Program include supplemental Medicare benefits, hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

Pursuant to the Company's agreement with AARP, program assets are managed separately from the Company's general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon any transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to the entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts, accrued interest and other miscellaneous amounts due to the Company.

The Company's pharmacy care services businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The pharmacy care services businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms and record rebates attributable to affiliated clients as a reduction to medical costs. The Company generally receives rebates two to five months after billing. As of December 31, 2020 and 2019, total pharmaceutical manufacturer rebates receivable included in other receivables in the Consolidated Balance Sheets amounted to $6.3 billion and $4.7 billion, respectively.

As of December 31, 2020 and 2019, the Company's Medicare Part D receivables amounted to $2.9 billion and $2.3 billion, respectively.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 10 years
Buildings	35 to 40 years
Capitalized software	3 to 5 years

Leasehold improvements are depreciated over the shorter of the remaining lease term or their estimated useful economic life.

Operating Leases

The Company leases facilities and equipment under long-term operating leases which are non-cancelable and expire on various dates. At the lease commencement date, lease right-of-use (ROU) assets and lease liabilities are recognized based on the present value of the future minimum lease payments over the lease term, which includes all fixed obligations arising from the lease contract. If an interest rate is not implicit in a lease, the Company utilizes its incremental borrowing rate for a period closely matching the lease term.

The Company's ROU assets are included in other assets, and lease liabilities are included in other current liabilities and other liabilities in the Company's Consolidated Balance Sheet.

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs impairment tests. The Company may first assess qualitative factors to determine if it is more likely than not the carrying value of a reporting unit exceeds its estimated fair value. The Company may also elect to skip the qualitative testing and proceed directly to the quantitative testing. When performing quantitative testing, the Company first estimates the fair values of its reporting units using discounted cash flows or a weighted

combination of discounted cash flows and a market-based method. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, discount rates and the selection of comparable peer companies. If the fair value is less than the carrying value of the reporting unit, an impairment is recognized for the difference, up to the carrying amount of goodwill.

There was no impairment of goodwill during the year ended December 31, 2020.

Intangible Assets

The Company's intangible assets are subject to impairment tests when events or circumstances indicate an intangible asset (or asset group) may be impaired. The Company's indefinite-lived intangible assets are also tested for impairment annually. There was no impairment of intangible assets during the year ended December 31, 2020.

Other Current Liabilities

Other current liabilities include health savings account deposits ($10.2 billion and $8.3 billion as of December 31, 2020 and 2019, respectively), the RSF associated with the AARP Program, accruals for premium rebates payable, the current portion of future policy benefits and customer balances.

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short duration customer contracts are primarily charged to expense as incurred.

Redeemable Noncontrolling Interests

Redeemable noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The following table provides details of the Company's redeemable noncontrolling interests' activity for the years ended December 31, 2020 and 2019:

(in millions)	2020	2019
Redeemable noncontrolling interests, beginning of period	$1,726	$1,908
Net earnings	112	115
Acquisitions	321	90
Redemptions	—	(618)
Distributions	(149)	(69)
Fair value and other adjustments	201	300
Redeemable noncontrolling interests, end of period	$2,211	$1,726

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably, primarily over four years and compensation expense related to restricted shares is based on the share price on the date of grant. Stock options vest ratably primarily over four years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options

is based on the fair value at the date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP), eligible employees are allowed to purchase the Company's stock at a discounted price, which is 90% of the market price of the Company's common stock at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic earnings per common share attributable to UnitedHealth Group common shareholders by dividing net earnings attributable to UnitedHealth Group common shareholders by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share attributable to UnitedHealth Group common shareholders using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, restricted shares and the ESPP (collectively, common stock equivalents), using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise and the average unrecognized compensation cost. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

ACA Tax

The ACA included an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. After a moratorium in 2019, the industry wide amount of the Health Insurance Industry Tax for 2020, which was primarily borne by the customer, was $15.5 billion, of which the Company's portion was approximately $3.0 billion. The Health Insurance Industry Tax was permanently repealed by Congress, effective January 1, 2021.

Recently Adopted Accounting Standards

In June 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2016-13, "Financial Instruments—Credit Losses (Topic 326)" (ASU 2016-13). ASU 2016-13 requires the use of the current expected credit loss impairment model to develop an estimate of expected credit losses for certain financial assets. ASU 2016-13 also requires expected credit losses on available-for-sale debt securities to be recognized through an allowance for credit losses and revises certain disclosure requirements. The Company adopted ASU 2016-13 on January 1, 2020 using a cumulative effect upon adoption approach. The adoption of ASU 2016-13 was immaterial to the Company's consolidated balance sheet, results of operations, equity and cash flows.

The Company has determined there have been no other recently adopted or issued accounting standards which had, or will have, a material impact on its Consolidated Financial Statements.

3. Investments

A summary of debt securities by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2020				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,335	$ 133	$ (3)	$ 3,465
State and municipal obligations	6,893	435	—	7,328
Corporate obligations	18,886	863	(12)	19,737
U.S. agency mortgage-backed securities	6,849	245	(3)	7,091
Non-U.S. agency mortgage-backed securities	2,116	95	(4)	2,207
Total debt securities — available-for-sale	38,079	1,771	(22)	39,828
Debt securities — held-to-maturity:				
U.S. government and agency obligations	420	6	—	426
State and municipal obligations	31	2	—	33
Corporate obligations	187	1	—	188
Total debt securities — held-to-maturity	638	9	—	647
Total debt securities	$ 38,717	$ 1,780	$ (22)	$ 40,475
December 31, 2019				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,502	$ 55	$ (4)	$ 3,553
State and municipal obligations	5,680	251	(5)	5,926
Corporate obligations	17,910	343	(11)	18,242
U.S. agency mortgage-backed securities	6,425	109	(6)	6,528
Non-U.S. agency mortgage-backed securities	1,811	37	(3)	1,845
Total debt securities — available-for-sale	35,328	795	(29)	36,094
Debt securities — held-to-maturity:				
U.S. government and agency obligations	402	2	—	404
State and municipal obligations	32	2	—	34
Corporate obligations	538	—	(1)	537
Total debt securities — held-to-maturity	972	4	(1)	975
Total debt securities	$ 36,300	$ 799	$ (30)	$ 37,069

Nearly all of the Company's investments in mortgage-backed securities were rated "Triple A" as of December 31, 2020.

The Company held $2.3 billion and $2.0 billion of equity securities as of December 31, 2020 and December 31, 2019, respectively. The Company's investments in equity securities primarily consist of employee savings plan related investments and shares of Brazilian real denominated fixed-income funds with readily determinable fair values. Additionally, the Company's investments included $1.3 billion and $1.4 billion of equity method investments in operating businesses in the health care sector, as of December 31, 2020 and 2019, respectively. The allowance for credit losses on held-to-maturity securities at December 31, 2020 was not material.

The amortized cost and fair value of debt securities as of December 31, 2020, by contractual maturity, were as follows:

(in millions)	Available-for-Sale		Held-to-Maturity	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	$ 2,951	$ 2,966	$ 348	$ 349
Due after one year through five years	11,638	12,088	241	245
Due after five years through ten years	10,212	10,931	27	29
Due after ten years	4,313	4,545	22	24
U.S. agency mortgage-backed securities	6,849	7,091	—	—
Non-U.S. agency mortgage-backed securities	2,116	2,207	—	—
Total debt securities	$ 38,079	$ 39,828	$ 638	$ 647

The fair value of available-for-sale debt securities with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

(in millions)	Less Than 12 Months		12 Months or Greater		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2020						
U.S. government and agency obligations	$ 346	$ (3)	$ —	$ —	$ 346	$ (3)
Corporate obligations	1,273	(9)	456	(3)	1,729	(12)
U.S. agency mortgage-backed securities	601	(3)	—	—	601	(3)
Non-U.S. agency mortgage-backed securities	195	(1)	93	(3)	288	(4)
Total debt securities — available-for-sale	$ 2,415	$ (16)	$ 549	$ (6)	$ 2,964	$ (22)
December 31, 2019						
U.S. government and agency obligations	$ 616	$ (4)	$ —	$ —	$ 616	$ (4)
State and municipal obligations	440	(5)	—	—	440	(5)
Corporate obligations	1,903	(7)	740	(4)	2,643	(11)
U.S. agency mortgage-backed securities	657	(3)	333	(3)	990	(6)
Non-U.S. agency mortgage-backed securities	406	(3)	—	—	406	(3)
Total debt securities — available-for-sale	$ 4,022	$ (22)	$ 1,073	$ (7)	$ 5,095	$ (29)

The Company's unrealized losses from all securities as of December 31, 2020 were generated from approximately 2,000 positions out of a total of 36,000 positions. The Company believes it will collect the timely principal and interest due on its debt securities having an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities which impacted the Company's assessment on collectability of principal and interest. At each reporting period, the Company evaluates available-for-sale debt securities for any credit-related impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the expected cash flows, the underlying credit quality and credit ratings of the issuers, and the potential economic impacts of COVID-19 on the issuers, noting no significant credit deterioration since purchase. As of December 31, 2020, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary. The allowance for credit losses on available-for-sale debt securities at December 31, 2020 was not material.

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input which is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1—Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2—Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs corroborated by other observable market data.

Level 3—Unobservable inputs cannot be corroborated by observable market data.

There were no transfers in or out of Level 3 financial assets or liabilities during the years ended December 31, 2020 or 2019.

Nonfinancial assets and liabilities or financial assets and liabilities measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2020 or 2019.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments which do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs currently observable in the markets for similar securities. Inputs often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and nonbinding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the

reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment to the prices obtained from the pricing service.

Fair values of debt securities which do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in corporate bonds, which are not a significant portion of our investments, are estimated using valuation techniques relying heavily on management assumptions and qualitative observations.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on such understanding.

Assets Under Management. Assets under management consists of debt securities and other investments held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Long-Term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2020				
Cash and cash equivalents	$ 16,841	$ 80	$ —	$16,921
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,241	224	—	3,465
State and municipal obligations	—	7,328	—	7,328
Corporate obligations	25	19,424	288	19,737
U.S. agency mortgage-backed securities	—	7,091	—	7,091
Non-U.S. agency mortgage-backed securities	—	2,207	—	2,207
Total debt securities — available-for-sale	3,266	36,274	288	39,828
Equity securities	1,795	33	—	1,828
Assets under management	1,774	2,250	52	4,076
Total assets at fair value	$ 23,676	$ 38,637	$ 340	$62,653
Percentage of total assets at fair value	38%	61%	1%	100%
December 31, 2019				
Cash and cash equivalents	$ 10,837	$ 148	$ —	$10,985
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,369	184	—	3,553
State and municipal obligations	—	5,926	—	5,926
Corporate obligations	70	17,923	249	18,242
U.S. agency mortgage-backed securities	—	6,528	—	6,528
Non-U.S. agency mortgage-backed securities	—	1,845	—	1,845
Total debt securities — available-for-sale	3,439	32,406	249	36,094
Equity securities	1,734	22	—	1,756
Assets under management	1,123	1,918	35	3,076
Total assets at fair value	$ 17,133	$ 34,494	$ 284	$51,911
Percentage of total assets at fair value	33%	66%	1%	100%

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2020					
Debt securities — held-to-maturity	$ 466	$ 108	$ 73	$ 647	$ 638
Long-term debt and other financing obligations	$ —	$ 51,254	$ —	$ 51,254	$ 42,171
December 31, 2019					
Debt securities — held-to-maturity	$ 541	$ 181	$ 253	$ 975	$ 972
Long-term debt and other financing obligations	$ —	$ 45,078	$ —	$ 45,078	$ 40,278

The carrying amounts reported on the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2020	December 31, 2019
Land and improvements	$ 533	$ 589
Buildings and improvements	4,759	4,705
Computer equipment	1,767	2,015
Furniture and fixtures	1,787	1,752
Less accumulated depreciation	(3,364)	(3,328)
Property and equipment, net	5,482	5,733
Capitalized software	5,010	4,638
Less accumulated amortization	(1,866)	(1,667)
Capitalized software, net	3,144	2,971
Total property, equipment and capitalized software, net	$ 8,626	$ 8,704

Depreciation expense for property and equipment for the years ended December 31, 2020, 2019 and 2018 was $997 million, $995 million and $924 million, respectively. Amortization expense for capitalized software for the years ended December 31, 2020, 2019 and 2018 was $814 million, $721 million and $606 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Consolidated
Balance at January 1, 2019	$ 26,400	$ 11,947	$ 5,772	$ 14,791	$ 58,910
Acquisitions	1,022	3,395	2,521	6	6,944
Foreign currency effects and other adjustments, net	(194)	—	(1)	—	(195)
Balance at December 31, 2019	27,228	15,342	8,292	14,797	65,659
Acquisitions	1,180	4,500	—	699	6,379
Foreign currency effects and other adjustments, net	(623)	2	(119)	39	(701)
Balance at December 31, 2020	$ 27,785	$ 19,844	$ 8,173	$ 15,535	$ 71,337

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

(in millions)	December 31, 2020 Gross Carrying Value	December 31, 2020 Accumulated Amortization	December 31, 2020 Net Carrying Value	December 31, 2019 Gross Carrying Value	December 31, 2019 Accumulated Amortization	December 31, 2019 Net Carrying Value
Customer-related	$ 13,428	$ (4,575)	$ 8,853	$ 12,968	$ (4,319)	$ 8,649
Trademarks and technology	1,597	(624)	973	1,186	(525)	661
Trademarks and other indefinite-lived	680	—	680	726	—	726
Other	606	(256)	350	541	(228)	313
Total	$ 16,311	$ (5,455)	$ 10,856	$ 15,421	$ (5,072)	$10,349

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

(in millions, except years)	2020 Fair Value	2020 Weighted-Average Useful Life	2019 Fair Value	2019 Weighted-Average Useful Life
Customer-related	$1,113	11 years	$1,750	13 years
Trademarks and technology	514	10 years	163	5 years
Other	95	10 years	119	11 years
Total acquired finite-lived intangible assets	$1,722	11 years	$2,032	13 years

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2021	$1,105
2022	998
2023	933
2024	887
2025	850

Amortization expense relating to intangible assets for the years ended December 31, 2020, 2019 and 2018 was $1.1 billion, $1.0 billion and $898 million, respectively.

7. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2020	2019	2018
Medical costs payable, beginning of period	$ 21,690	$ 19,891	$ 17,871
Acquisitions	316	679	339
Reported medical costs:			
Current year	160,276	157,020	145,723
Prior years	(880)	(580)	(320)
Total reported medical costs	159,396	156,440	145,403
Medical payments:			
Payments for current year	(139,974)	(137,155)	(127,155)
Payments for prior years	(19,556)	(18,165)	(16,567)
Total medical payments	(159,530)	(155,320)	(143,722)
Medical costs payable, end of period	$ 21,872	$ 21,690	$ 19,891

For the years ended December 31, 2020 and 2019 medical cost reserve development was primarily driven by lower than expected health system utilization levels. For the year ended December 31, 2018, no individual factors significantly impacted medical cost reserve development. Medical costs payable included IBNR of $14.8 billion and $13.8 billion at December 31, 2020 and 2019, respectively. Substantially all of the IBNR balance as of December 31, 2020 relates to the current year.

The following is information about incurred and paid medical cost development as of December 31, 2020:

(in millions)	Net Incurred Medical Costs For the Years Ended December 31,	
Year	2019	2020
2019	$ 157,020	$ 156,217
2020		160,276
Total		$ 316,493

(in millions)	Net Cumulative Medical Payments For the Years Ended December 31,	
Year	2019	2020
2019	$ (137,155)	$ (155,150)
2020		(139,974)
Total		(295,124)
Net remaining outstanding liabilities prior to 2019		503
Total medical costs payable		$ 21,872

8. Short-Term Borrowings and Long-Term Debt

Short-term borrowings and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	December 31, 2020			December 31, 2019		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial paper	$ 1,296	$ 1,296	$ 1,296	$ 400	$ 400	$ 400
2.700% notes due July 2020	—	—	—	1,500	1,499	1,506
Floating rate notes due October 2020	—	—	—	300	300	300
3.875% notes due October 2020	—	—	—	450	450	455
1.950% notes due October 2020	—	—	—	900	899	900
4.700% notes due February 2021	400	400	401	400	403	410
2.125% notes due March 2021	750	750	753	750	749	753
Floating rate notes due June 2021	350	350	350	350	349	350
3.150% notes due June 2021	400	400	405	400	399	407
3.375% notes due November 2021	500	507	509	500	501	512
2.875% notes due December 2021	750	762	768	750	753	765
2.875% notes due March 2022	1,100	1,113	1,127	1,100	1,087	1,121
3.350% notes due July 2022	1,000	999	1,048	1,000	998	1,036
2.375% notes due October 2022	900	897	935	900	896	911
0.000% notes due November 2022	15	14	14	15	13	14
2.750% notes due February 2023	625	644	654	625	624	638
2.875% notes due March 2023	750	789	793	750	770	770
3.500% notes due June 2023	750	748	809	750	747	786
3.500% notes due February 2024	750	747	821	750	746	792
2.375% notes due August 2024	750	747	799	750	747	760
3.750% notes due July 2025	2,000	1,992	2,279	2,000	1,990	2,161
3.700% notes due December 2025	300	298	344	300	298	325
1.250% notes due January 2026	500	496	515	—	—	—
3.100% notes due March 2026	1,000	997	1,121	1,000	996	1,048
3.450% notes due January 2027	750	747	859	750	746	804
3.375% notes due April 2027	625	620	714	625	620	667
2.950% notes due October 2027	950	940	1,067	950	939	988
3.850% notes due June 2028	1,150	1,143	1,367	1,150	1,142	1,269
3.875% notes due December 2028	850	844	1,019	850	843	941
2.875% notes due August 2029	1,000	1,086	1,137	1,000	993	1,029
2.000% notes due May 2030	1,250	1,234	1,326	—	—	—
4.625% notes due July 2035	1,000	992	1,340	1,000	992	1,215
5.800% notes due March 2036	850	839	1,271	850	838	1,129
6.500% notes due June 2037	500	492	800	500	492	712
6.625% notes due November 2037	650	641	1,044	650	641	940
6.875% notes due February 2038	1,100	1,077	1,802	1,100	1,076	1,631
3.500% notes due August 2039	1,250	1,241	1,487	1,250	1,241	1,313
2.750% notes due May 2040	1,000	964	1,085	—	—	—
5.700% notes due October 2040	300	296	451	300	296	396
5.950% notes due February 2041	350	346	540	350	345	475
4.625% notes due November 2041	600	589	820	600	589	716
4.375% notes due March 2042	502	485	661	502	484	580
3.950% notes due October 2042	625	608	790	625	607	688
4.250% notes due March 2043	750	735	982	750	735	856
4.750% notes due July 2045	2,000	1,974	2,814	2,000	1,973	2,463
4.200% notes due January 2047	750	738	991	750	738	861
4.250% notes due April 2047	725	717	963	725	717	839
3.750% notes due October 2047	950	934	1,180	950	934	1,023
4.250% notes due June 2048	1,350	1,330	1,803	1,350	1,330	1,569
4.450% notes due December 2048	1,100	1,086	1,517	1,100	1,086	1,316
3.700% notes due August 2049	1,250	1,235	1,567	1,250	1,235	1,344
2.900% notes due May 2050	1,250	1,208	1,384	—	—	—
3.875% notes due August 2059	1,250	1,228	1,618	1,250	1,228	1,350
3.125% notes due May 2060	1,000	965	1,161	—	—	—
Total short-term borrowings and long-term debt	$42,563	$42,280	$51,301	$39,817	$39,474	$44,234

The Company's long-term debt obligations also included $1.2 billion of other financing obligations as of both December 31, 2020 and 2019, of which $354 million and $322 million were current as of December 31, 2020 and 2019, respectively.

Maturities of short-term borrowings and long-term debt for the years ending December 31 are as follows:

(in millions)	
2021	$ 4,800
2022	3,180
2023	2,290
2024	1,665
2025	2,465
Thereafter	29,349

Short-Term Borrowings

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of December 31, 2020, the Company's outstanding commercial paper had a weighted-average annual interest rate of 0.2%.

The Company has $4.4 billion five-year, $4.4 billion three-year and $3.8 billion 364-day revolving bank credit facilities with 26 banks, which mature in December 2025, December 2023 and December 2021, respectively. These facilities provide full liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of December 31, 2020, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of December 31, 2020, annual interest rates would have ranged from 0.8% to 1.0%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including requiring the Company to maintain a debt to debt-plus-shareholders' equity ratio of not more than 60%. The Company was in compliance with its debt covenants as of December 31, 2020.

9. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2020	2019	2018
Current Provision:			
Federal	$4,098	$2,629	$2,897
State and local	392	319	219
Foreign	491	564	404
Total current provision	4,981	3,512	3,520
Deferred (benefit) provision	(8)	230	42
Total provision for income taxes	$4,973	$3,742	$3,562

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	2020		2019		2018	
Tax provision at the U.S. federal statutory rate	$4,356	21.0%	$3,776	21.0%	$3,348	21.0%
State income taxes, net of federal benefit	315	1.5	271	1.5	168	1.0
Share-based awards — excess tax benefit	(130)	(0.6)	(132)	(0.7)	(161)	(1.0)
Non-deductible compensation	134	0.7	119	0.7	117	0.7
Health insurance tax	626	3.0	—	—	552	3.5
Foreign rate differential	(164)	(0.8)	(214)	(1.2)	(203)	(1.3)
Other, net	(164)	(0.8)	(78)	(0.5)	(259)	(1.6)
Provision for income taxes	$4,973	24.0%	$3,742	20.8%	$3,562	22.3%

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2020	2019
Deferred income tax assets:		
Accrued expenses and allowances	$ 815	$ 654
U.S. federal and state net operating loss carryforwards	276	260
Share-based compensation	98	97
Nondeductible liabilities	252	184
Non-U.S. tax loss carryforwards	340	420
Lease liability	1,200	892
Other-domestic	126	179
Other-non-U.S.	454	329
Subtotal	3,561	3,015
Less: valuation allowances	(170)	(147)
Total deferred income tax assets	3,391	2,868
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(2,588)	(2,370)
Non-U.S. goodwill and intangible assets	(606)	(735)
Capitalized software	(731)	(683)
Depreciation and amortization	(346)	(301)
Prepaid expenses	(216)	(172)
Outside basis in partnerships	(342)	(317)
Lease right-of-use asset	(1,179)	(887)
Net unrealized gains on investments	(400)	(177)
Other-non-U.S.	(350)	(219)
Total deferred income tax liabilities	(6,758)	(5,861)
Net deferred income tax liabilities	$(3,367)	$(2,993)

Valuation allowances are provided when it is considered more likely than not deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Gross federal net operating loss carryforwards of $100 million expire beginning in 2023 through 2037 and $309 million have an indefinite carryforward period; state net operating loss carryforwards expire beginning in 2021 through 2040, with some having an indefinite carryforward period. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2020, the Company's undistributed earnings from non-U.S. subsidiaries are intended to be indefinitely reinvested in non-U.S. operations, and therefore no U.S. deferred taxes have been recorded. Taxes payable on the remittance of such earnings would be minimal.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2020	2019	2018
Gross unrecognized tax benefits, beginning of period	$1,423	$1,056	$ 598
Gross increases:			
Current year tax positions	416	512	487
Prior year tax positions	120	2	87
Gross decreases:			
Prior year tax positions	(130)	(96)	(84)
Settlements	—	(46)	(20)
Statute of limitations lapses	—	(5)	(12)
Gross unrecognized tax benefits, end of period	$1,829	$1,423	$1,056

The Company believes it is reasonably possible its liability for unrecognized tax benefits will decrease in the next twelve months by $39 million as a result of audit settlements and the expiration of statutes of limitations.

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Statements of Operations. During the years ended December 31, 2020, 2019 and 2018, the Company recognized $52 million, $19 million and $6 million of interest and penalties, respectively. The Company had $128 million and $76 million of accrued interest and penalties for uncertain tax positions as of December 31, 2020 and 2019, respectively. These amounts are not included in the reconciliation above. As of December 31, 2020, there were $1.0 billion of unrecognized tax benefits which, if recognized, would affect the effective tax rate.

The Company currently files income tax returns in the United States, various states and localities and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2016 and prior. The Company's 2017 through 2020 tax years are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to the 2013 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2015 and forward.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated insurance and health maintenance organization (HMO) subsidiaries are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions which may be paid to their parent companies. In the United States, most of these state regulations and standards are generally consistent with model regulations established by the National Association of Insurance Commissioners. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

For the year ended December 31, 2020, the Company's domestic insurance and HMO subsidiaries paid their parent companies dividends of $8.3 billion, including $4.2 billion of extraordinary dividends. For the year ended December 31, 2019, the Company's domestic insurance and HMO subsidiaries paid their parent companies dividends of $5.6 billion, including $1.3 billion of extraordinary dividends.

The Company's global financially regulated subsidiaries had estimated aggregate statutory capital and surplus of $29.6 billion as of December 31, 2020. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's global financially regulated subsidiaries was approximately $11.9 billion as of December 31, 2020.

Optum Bank must meet minimum capital requirements of the Federal Deposit Insurance Corporation (FDIC) under the capital adequacy rules to which it is subject. At December 31, 2020, the Company believes Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2018, the Board renewed the Company's share repurchase program with an authorization to repurchase up to 100 million shares of its common stock.

A summary of common share repurchases for the years ended December 31, 2020 and 2019 is as follows:

	Years Ended December 31,	
(in millions, except per share data)	**2020**	**2019**
Common share repurchases, shares	14	22
Common share repurchases, average price per share	$ 300.58	$ 245.97
Common share repurchases, aggregate cost	$ 4,250	$ 5,500
Board authorized shares remaining	58	72

Dividends

In June 2020, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of $5.00 compared to $4.32 per share, which the Company had paid since June 2019. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of the Company's 2020 dividend payments:

Payment Date	**Amount per Share**	**Total Amount Paid**
		(in millions)
March 24	$ 1.08	$ 1,024
June 30	1.25	1,188
September 22	1.25	1,188
December 15	1.25	1,184

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options and restricted shares. In June 2020, the Company's Board of Directors approved 48 million additional shares under the Plan.

As of December 31, 2020, the Company had 71 million shares available for future grants of share-based awards under the Plan. As of December 31, 2020, there were also 4 million shares of common stock available for issuance under the ESPP.

Stock Options

Stock option activity for the year ended December 31, 2020 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	32	$ 166		
Granted	7	311		
Exercised	(10)	126		
Forfeited	(1)	255		
Outstanding at end of period	28	211	6.6	$ 3,937
Exercisable at end of period	13	150	5.0	2,579
Vested and expected to vest, end of period	27	210	6.5	3,892

Restricted Shares

Restricted share activity for the year ended December 31, 2020 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	5	$ 207
Granted	1	303
Vested	(2)	187
Nonvested at end of period	4	256

Other Share-Based Compensation Data

	For the Years Ended December 31,		
(in millions, except per share amounts)	2020	2019	2018
Stock Options			
Weighted-average grant date fair value of shares granted, per share	$ 54	$ 46	$ 43
Total intrinsic value of stock options exercised	1,736	1,398	1,431
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	303	259	229
Total fair value of restricted shares vested	$ 574	$ 545	$ 521
Employee Stock Purchase Plan			
Number of shares purchased	1	1	2
Share-Based Compensation Items			
Share-based compensation expense, before tax	$ 679	$ 697	$ 638
Share-based compensation expense, net of tax effects	619	641	587
Income tax benefit realized from share-based award exercises	208	201	239

(in millions, except years)	December 31, 2020
Unrecognized compensation expense related to share awards	$ 805
Weighted-average years to recognize compensation expense	1.4

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options were as follows:

	For the Years Ended December 31,		
	2020	2019	2018
Risk-free interest rate	0.2% - 1.4%	1.5% - 2.5%	2.6% - 3.1%
Expected volatility	22.2% - 29.5%	19.4% - 21.6%	18.7% - 19.3%
Expected dividend yield	1.4% - 1.7%	1.4% - 1.8%	1.3% - 1.5%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	5.1	5.3	5.6

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option exercises and forfeitures within the valuation model. The expected lives of options granted represents the period of time the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2020, 2019 and 2018.

In addition, the Company maintains non-qualified, deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus. The deferrals are recorded within long-term investments with an approximately equal amount in other liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $1.6 billion and $1.4 billion as of December 31, 2020 and 2019, respectively.

12. Commitments and Contingencies

Leases

Operating lease costs were $1.1 billion, $1.0 billion and $751 million for the years ended December 31, 2020, 2019 and 2018, respectively, and included immaterial variable and short-term lease costs for the year ended December 31, 2020 and 2019. Cash payments made on the Company's operating lease liabilities were $865 million and $746 million for the years ended December 31, 2020 and 2019, respectively, which were classified within operating activities in the Consolidated Statements of Cash Flows. As of December 31, 2020, the Company's weighted-average remaining lease term and weighted-average discount rate for its operating leases were 8.7 years and 3.0%, respectively.

As of December 31, 2020, future minimum annual lease payments under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2021	$ 865
2022	775
2023	646
2024	538
2025	441
Thereafter	1,781
Total future minimum lease payments	5,046
Less imputed interest	(599)
Total	$ 4,447

Other Commitments

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2020, 2019 or 2018.

As of December 31, 2020, the Company had outstanding, undrawn letters of credit with financial institutions of $134 million and surety bonds outstanding with insurance companies of $1.2 billion, primarily to bond contractual performance.

Pending Acquisitions

In the fourth quarter of 2020, the Company entered into agreements to acquire multiple companies in the health care sector, which are expected to close in the first half of 2021, subject to regulatory approval and other customary closing conditions. Additionally, in January 2021, the Company entered into agreements to purchase multiple companies in the health care sector, most notably, Change Healthcare (NASDAQ: CHNG). This acquisition is expected to close in the second half of 2021, subject to Change Healthcare shareholders' approval, regulatory approvals and other customary closing conditions. The total anticipated capital required for these acquisitions, excluding the payoff of acquired indebtedness, is approximately $13 billion.

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could

result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable a loss may be incurred.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice (DOJ), the SEC, the IRS, the U.S. Drug Enforcement Administration, the U.S. Department of Labor, the FDIC, the Defense Contract Audit Agency and other governmental authorities. Similarly, our international businesses are also subject to investigations, audits and reviews by applicable foreign governments, including South American and other non-U.S. governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans.

On February 14, 2017, the DOJ announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome which may result from this matter given its procedural status.

13. Business Combinations

During the year ended December 31, 2020, the Company completed several business combinations for total cash consideration of $7.9 billion.

The total consideration exceeded the fair value of the net tangible assets acquired by $8.1 billion, of which $1.7 billion has been allocated to finite-lived intangible assets and $6.4 billion to goodwill. The majority of goodwill is not deductible for income tax purposes.

Acquired tangible assets (liabilities) at acquisition date were:

(in millions)	
Cash and cash equivalents	$ 715
Accounts receivable and other current assets	735
Property, equipment and other long-term assets	816
Medical costs payable	(316)
Accounts payable and other current liabilities	(861)
Other long-term liabilities	(817)
Total net tangible assets	$ 272

The preliminary purchase price allocations for the various business combinations are subject to adjustment as valuation analyses, primarily related to intangible assets and contingent and tax liabilities, are finalized. See Note 6 for a summary of the acquisition date fair values and weighted-average useful lives assigned to acquired finite-lived intangible assets.

The results of operations and financial condition of acquired entities have been included in the Company's consolidated results and the results of the corresponding operating segment as of date of acquisition. Through December 31, 2020, acquired entities impact on revenue and net earnings was not material.

Unaudited pro forma revenues for the years ended December 31, 2020 and 2019 as if the acquisitions had occurred on January 1, 2019 were immaterial for both periods. The pro forma effects of the acquisitions on net earnings were immaterial for both years.

14. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics, products and services, customers, distribution methods and operational processes which operate in a similar regulatory environment are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global. The U.S. businesses share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology and consumer engagement infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide. UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State provides diversified health care benefits products and services to state programs caring for the economically disadvantaged and the medically underserved. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, the Children's Health Insurance Program and other federal, state and community health care programs. UnitedHealthcare Global provides health and dental benefits and hospital and clinical services to employer groups and individuals in South America, and other diversified global health businesses.
- *OptumHealth* focuses on care delivery, care management, wellness and consumer engagement, and health financial services. OptumHealth is building a comprehensive, connected health care delivery and engagement platform by directly providing high-quality care, helping people manage chronic and complex health needs, and proactively engaging consumers in managing their health through in-person, virtual and digital clinical platforms. OptumHealth offers access to networks of care provider specialists, health management services, care delivery, consumer engagement and financial services.
- *OptumInsight* brings together advanced analytics, technology and health care expertise to deliver integrated services and solutions. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations comprising the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.
- *OptumRx* offers pharmacy care services and programs, including retail network contracting, home delivery, specialty and community health pharmacy services, purchasing and clinical capabilities, and develops programs in areas such as step therapy, formulary management, drug adherence and disease/drug therapy management. OptumRx integrates pharmacy and medical care and is positioned to serve patients with complex clinical needs and consumers looking for a better digital pharmacy experience with transparent pricing.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy care products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and local care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Transactions with affiliated customers are eliminated in consolidation. Assets and liabilities jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned so each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 36%, 33% and 30% for 2020, 2019 and 2018, respectively, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 97%, 96% and 96% of consolidated total revenues for 2020, 2019 and 2018, respectively. Long-lived fixed assets located in the United States represented approximately 75% and 72% of the total long-lived fixed assets as of December 31, 2020 and 2019, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Global.

The following table presents the reportable segment financial information:

(in millions)	UnitedHealthcare	Optum					Corporate and Eliminations	Consolidated
		OptumHealth	OptumInsight	OptumRx	Optum Eliminations	Optum		
2020								
Revenues — unaffiliated customers:								
Premiums	$ 191,679	$ 9,799	$ —	$ —	$ —	$ 9,799	$ —	$ 201,478
Products	—	33	135	33,977	—	34,145	—	34,145
Services	8,464	6,815	3,687	1,050	—	11,552	—	20,016
Total revenues — unaffiliated customers	200,143	16,647	3,822	35,027	—	55,496	—	255,639
Total revenues — affiliated customers	—	22,481	6,941	52,420	(1,800)	80,042	(80,042)	—
Investment and other income	732	680	39	51	—	770	—	1,502
Total revenues	$ 200,875	$ 39,808	$ 10,802	$ 87,498	$ (1,800)	$ 136,308	$ (80,042)	$ 257,141
Earnings from operations	$ 12,359	$ 3,434	$ 2,725	$ 3,887	$ —	$ 10,046	$ —	$ 22,405
Interest expense	—	—	—	—	—	—	(1,663)	(1,663)
Earnings before income taxes	$ 12,359	$ 3,434	$ 2,725	$ 3,887	$ —	$ 10,046	$ (1,663)	$ 20,742
Total assets	$ 98,229	$ 52,073	$ 15,425	$ 39,280	$ —	$ 106,778	$ (7,718)	$ 197,289
Purchases of property, equipment and capitalized software	687	715	461	188	—	1,364	—	2,051
Depreciation and amortization	920	703	670	598	—	1,971	—	2,891
2019								
Revenues — unaffiliated customers:								
Premiums	$ 183,783	$ 5,916	$ —	$ —	$ —	$ 5,916	$ —	$ 189,699
Products	—	31	116	31,450	—	31,597	—	31,597
Services	8,922	5,732	3,630	689	—	10,051	—	18,973
Total revenues — unaffiliated customers	192,705	11,679	3,746	32,139	—	47,564	—	240,269
Total revenues — affiliated customers	—	17,966	6,239	42,093	(1,661)	64,637	(64,637)	—
Investment and other income	1,137	672	21	56	—	749	—	1,886
Total revenues	$ 193,842	$ 30,317	$ 10,006	$ 74,288	$ (1,661)	$ 112,950	$ (64,637)	$ 242,155
Earnings from operations	$ 10,326	$ 2,963	$ 2,494	$ 3,902	$ —	$ 9,359	$ —	$ 19,685
Interest expense	—	—	—	—	—	—	(1,704)	(1,704)
Earnings before income taxes	$ 10,326	$ 2,963	$ 2,494	$ 3,902	$ —	$ 9,359	$ (1,704)	$ 17,981
Total assets	$ 88,250	$ 40,444	$ 15,181	$ 36,346	$ —	$ 91,971	$ (6,332)	$ 173,889
Purchases of property, equipment and capitalized software	841	573	495	162	—	1,230	—	2,071
Depreciation and amortization	926	565	672	557	—	1,794	—	2,720
2018								
Revenues — unaffiliated customers:								
Premiums	$ 174,282	$ 3,805	$ —	$ —	$ —	$ 3,805	$ —	$ 178,087
Products	—	52	111	29,438	—	29,601	—	29,601
Services	8,366	4,925	3,280	612	—	8,817	—	17,183
Total revenues — unaffiliated customers	182,648	8,782	3,391	30,050	—	42,223	—	224,871
Total revenues — affiliated customers	—	14,882	5,596	39,440	(1,409)	58,509	(58,509)	—
Investment and other income	828	481	21	46	—	548	—	1,376
Total revenues	$ 183,476	$ 24,145	$ 9,008	$ 69,536	$ (1,409)	$ 101,280	$ (58,509)	$ 226,247
Earnings from operations	$ 9,113	$ 2,430	$ 2,243	$ 3,558	$ —	$ 8,231	$ —	$ 17,344
Interest expense	—	—	—	—	—	—	(1,400)	(1,400)
Earnings before income taxes	$ 9,113	$ 2,430	$ 2,243	$ 3,558	$ —	$ 8,231	$ (1,400)	$ 15,944
Total assets	$ 82,938	$ 29,837	$ 11,039	$ 33,912	$ —	$ 74,788	$ (5,505)	$ 152,221
Purchases of property, equipment and capitalized software	761	593	517	192	—	1,302	—	2,063
Depreciation and amortization	845	439	654	490	—	1,583	—	2,428

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) designed to provide reasonable assurance the information required to be disclosed by us in reports we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2020. Based upon their evaluation, our Chief Executive Officer and Chief Financial Officer concluded our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2020.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2020 which have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control Over Financial Reporting as of December 31, 2020

Management of UnitedHealth Group Incorporated and Subsidiaries (the Company) is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2020. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in Internal Control-Integrated Framework (2013). Based on our assessment and the COSO criteria, we believe that, as of December 31, 2020, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2020, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2020, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2020, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2020, of the Company and our report dated March 1, 2021, expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2020. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
March 1, 2021

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

DIRECTORS OF THE REGISTRANT

The following sets forth certain information regarding our directors as of March 1, 2021, including their name and principal occupation or employment:

Richard T. Burke
Lead Independent Director
UnitedHealth Group

Timothy P. Flynn
Retired Chair
KPMG International

Stephen J. Hemsley
Chair
UnitedHealth Group

Michele J. Hooper
President and Chief Executive Officer
The Directors' Council

F. William McNabb III
Former Chairman and Chief Executive Officer
The Vanguard Group, Inc.

Valerie Montgomery Rice, M.D.
President and Dean
Morehouse School of Medicine

John H. Noseworthy, M.D.
Former Chief Executive Officer and President
Mayo Clinic

Glenn M. Renwick
Former Chairman and Chief Executive Officer
The Progressive Corporation

Gail R. Wilensky, Ph.D.
Senior Fellow
Project HOPE

Andrew P. Witty
Chief Executive Officer
UnitedHealth Group

Pursuant to General Instruction G(3) to Form 10-K and the Instruction to Item 401 of Regulation S-K, information regarding our executive officers is provided in Part I, Item 1 under the caption "Executive Officers of the Registrant."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller and persons performing similar functions. The code of ethics, entitled Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at www.unitedhealthgroup.com. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business." We intend to satisfy the SEC's disclosure requirements regarding amendments to, or waivers of, the code of ethics for our senior financial officers by posting such information on our website indicated above.

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance" and "Proposal 1-Election of Directors" in our definitive proxy statement for our 2021 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402 and 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance—Risk Oversight" and

"Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2021 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED SHAREHOLDER MATTERS

The information required by section 201(d) and Item 403 of Regulation S-K will be included under the headings "Equity Compensation Plan Information" and "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2021 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2021 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Disclosure of Fees Paid to Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2021 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBIT AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2020 and 2019.
- Consolidated Statements of Operations for the years ended December 31, 2020, 2019, and 2018.
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2020, 2019, and 2018.
- Consolidated Statements of Changes in Equity for the years ended December 31, 2020, 2019, and 2018.
- Consolidated Statements of Cash Flows for the years ended December 31, 2020, 2019, and 2018.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

- Schedule I—Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

(b) The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

EXHIBIT INDEX**

3.1	Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A, Commission File No. 1-10864, filed on July 1, 2015)
3.2	Amended and Restated Bylaws of UnitedHealth Group Incorporated, effective February 23, 2021 (incorporated by reference to Exhibit 3.2 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on February 26, 2021)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated as of November 15, 1988, amended as of November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
4.5	Description of Common Stock (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.1	UnitedHealth Group 2020 Stock Incentive Plan (incorporated by UnitedHealth Group 2020 Stock Incentive Plan (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8, SEC File Number 333-238854, filed on June 1, 2020)
*10.2	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2020)
*10.3	Form of Agreement for Nonqualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2020)
*10.4	Form of Agreement for Performance-Based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2020)

*10.5	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2020)
10.6	Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on July 1, 2015)
*10.7	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.8	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.9	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.10	Second Amendment, dated as of November 5, 2015, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.11	UnitedHealth Group Executive Savings Plan (2021 Statement)
*10.12	Summary of Non-Management Director Compensation, effective as of September 1, 2020
*10.13	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.14	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009)
*10.15	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.16	Catamaran Corporation Third Amended and Restated Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.17	Catalyst Health Solutions, Inc. 2006 Stock Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.18	Audax Health Solutions, Inc. 2010 Equity Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 to Registration Statement on Form S-8, SEC File Number 333-205826, filed on February 15, 2017)
*10.19	Surgical Care Affiliates, Inc. 2016 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)

*10.20	Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.21	Surgical Care Affiliates, Inc. Management Equity Incentive Plan (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.22	Surgical Care Affiliates, Inc. Directors and Consultants Equity Incentive Plan (incorporated by reference to Exhibit 4.6 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.23	The Advisory Board Company Amended and Restated 2009 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on June 15, 2015)
*10.24	The Advisory Board Company 2005 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on November 17, 2005)
*10.25	Amended and Restated Employment Agreement, effective as of December 1, 2014, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.26	Amendment to Employment Agreement, effective as of August 16, 2017, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017)
*10.27	Amended and Restated Employment Agreement, dated as of June 7, 2016, between United HealthCare Services, Inc. and John Rex (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
*10.28	Amended and Restated Employment Agreement, dated February 3, 2021 between the Company and Andrew P. Witty (incorporated by reference to Exhibit 5.02 to UnitedHealth Group Incorporated's Current Report on Form8-K filed on February 8, 2021)
*10.29	Amended and Restated Employment Agreement, effective as of March 16, 2015, between United HealthCare Services, Inc. and Dirk McMahon (incorporated by reference to Exhibit 10.44 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.30	Amendment to Employment Agreement, effective as of May 31, 2017, between United HealthCare Services, Inc. and Dirk McMahon (incorporated by reference to Exhibit 10.45 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.31	Amendment to Employment Agreement, effective as of March 12, 2019, between United HealthCare Services, Inc. and Dirk McMahon (incorporated by reference to Exhibit 10.46 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.32	Employment Agreement, effective as of October 31, 2019, between United HealthCare Services, Inc. and Patricia Lewis
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements")

21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS	XBRL Instance Document—the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document.
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document.
104	Cover Page Interactive Data File (formatted as Inline XBRL and embedded within Exhibit 101).

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* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

Schedule I—Condensed Financial Information of Registrant (Parent Company Only).

Schedule I

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statement Schedule

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2020 and 2019, and for each of the three years in the period ended December 31, 2020, and the Company's internal control over financial reporting as of December 31, 2020, and have issued our reports thereon dated March 1, 2021; such reports are included elsewhere in this Form 10-K. Our audits also included the financial statement schedule of the Company listed in the Index at Item 15. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statement schedule based on our audits. In our opinion, the financial statement schedule, when considered in relation to the consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
March 1, 2021

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2020	December 31, 2019
Assets		
Current assets:		
Cash and cash equivalents	$ 258	$ 46
Other current assets	562	787
Total current assets	820	833
Equity in net assets of subsidiaries	107,714	93,467
Long-term notes receivable from subsidiaries	5,021	5,079
Other assets	342	794
Total assets	$ 113,897	$ 100,173
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 589	$ 688
Current portion of notes payable to subsidiaries	4,882	750
Short-term borrowings and current maturities of long-term debt	4,465	3,548
Total current liabilities	9,936	4,986
Long-term debt, less current maturities	37,815	35,926
Long-term notes payable to subsidiaries	—	1,314
Other liabilities	655	331
Total liabilities	48,406	42,557
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 946 and 948 issued and outstanding	10	9
Additional paid-in capital	—	7
Retained earnings	69,295	61,178
Accumulated other comprehensive loss	(3,814)	(3,578)
Total UnitedHealth Group shareholders' equity	65,491	57,616
Total liabilities and shareholders' equity	$ 113,897	$ 100,173

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2020	2019	2018
Revenues:			
Investment and other income	$ 194	$ 209	$ 194
Total revenues	194	209	194
Operating costs:			
Operating costs	27	38	35
Interest expense	1,594	1,580	1,285
Total operating costs	1,621	1,618	1,320
Loss before income taxes	(1,427)	(1,409)	(1,126)
Benefit for income taxes	300	293	251
Loss of parent company	(1,127)	(1,116)	(875)
Equity in undistributed income of subsidiaries	16,530	14,955	12,861
Net earnings	15,403	13,839	11,986
Other comprehensive (loss) income	(236)	582	(1,517)
Comprehensive income	$ 15,167	$ 14,421	$ 10,469

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2020	2019	2018
Operating activities			
Cash flows from operating activities	$8,842	$9,275	$6,099
Investing activities			
Issuances of notes to subsidiaries	(628)	(2,722)	(1,420)
Repayments of notes to subsidiaries	1,089	2,249	1,419
Cash paid for acquisitions	(7,706)	(9,645)	(4,066)
Return of capital to parent company	943	4,497	4,196
Capital contributions to subsidiaries	(43)	(803)	(1,259)
Other, net	143	490	4
Cash flows used for investing activities	(6,202)	(5,934)	(1,126)
Financing activities			
Common stock repurchases	(4,250)	(5,500)	(4,500)
Proceeds from common stock issuances	1,440	1,037	838
Cash dividends paid	(4,584)	(3,932)	(3,320)
Proceeds from (repayments of) short-term borrowings, net	872	300	(201)
Proceeds from issuance of long-term debt	4,864	5,444	6,935
Repayments of long-term debt	(3,150)	(1,750)	(2,600)
Proceeds (repayments) of notes from subsidiaries	2,818	1,207	(1,127)
Other, net	(438)	(535)	(923)
Cash flows used for financing activities	(2,428)	(3,729)	(4,898)
Increase (decrease) in cash and cash equivalents	212	(388)	75
Cash and cash equivalents, beginning of period	46	434	359
Cash and cash equivalents, end of period	$ 258	$ 46	$ 434
Supplemental cash flow disclosures			
Cash paid for interest	$1,633	$1,506	$1,294
Cash paid for income taxes	4,185	2,590	2,379

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends and Capital Distributions. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $10.0 billion, $5.6 billion and $5.6 billion in 2020, 2019 and 2018, respectively. Additionally, $0.9 billion, $4.5 billion and $4.2 billion in cash were received as a return of capital to the parent company during 2020, 2019 and 2018, respectively.

3. Short-Term Borrowings and Long-Term Debt

Discussion of short-term borrowings and long-term debt can be found in Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements." Long-term debt obligations of the parent company do not include other financing obligations at subsidiaries which totaled $1.2 billion at December 31, 2020 and 2019.

Maturities of short-term borrowings and long-term debt for the years ending December 31 are as follows:

(in millions)	
2021	$ 4,446
2022	3,015
2023	2,125
2024	1,500
2025	2,300
Thereafter	29,177

UnitedHealth Group's parent company had notes payable to subsidiaries of $4.9 billion as of December 31, 2020, which included on-demand features.

4. Commitments and Contingencies

Certain regulated subsidiaries are guaranteed by UnitedHealth Group's parent company in the event of insolvency. UnitedHealth Group's parent company also provides guarantees related to its service level under certain contracts. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2020, 2019 or 2018.

For a summary of commitments and contingencies, see Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Dated: March 1, 2021

UNITEDHEALTH GROUP INCORPORATED

By /s/ ANDREW P. WITTY

Andrew P. Witty
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ ANDREW P. WITTY **Andrew P. Witty**	Director and Chief Executive Officer (principal executive officer)	March 1, 2021
/s/ JOHN F. REX **John F. Rex**	Executive Vice President and Chief Financial Officer (principal financial officer)	March 1, 2021
/s/ THOMAS E. ROOS **Thomas E. Roos**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	March 1, 2021
* **Richard T. Burke**	Director	March 1, 2021
* **Timothy P. Flynn**	Director	March 1, 2021
* **Stephen J. Hemsley**	Director	March 1, 2021
* **Michele J. Hooper**	Director	March 1, 2021
* **F. William McNabb III**	Director	March 1, 2021
* **Valerie C. Montgomery Rice, M.D.**	Director	March 1, 2021
* **John H. Noseworthy, M.D.**	Director	March 1, 2021
* **Glenn M. Renwick**	Director	March 1, 2021
* **Gail R. Wilensky, Ph.D.**	Director	March 1, 2021

*By /s/ DANNETTE L. SMITH

Dannette L. Smith
As Attorney-in-Fact

Responses to Technical Questions (Tab 7)

Advancing Equitable Health Outcomes Through Community Investments

We are committed to building healthier communities by addressing social determinants of health and driving access to care. UnitedHealthcare granted $500,000 to four organizations making an impact on mental health care and equitable access to healthy, nutritious foods at a local level.

Kansans United

United Healthcare Community Plan

Experience and Qualifications (Tab 7a)

Expanding Access to Healthy Foods in Kansas Tribal Nations

American Indians experience barriers to accessing nutritious foods which can lead to poor health outcomes. To address these inequities, UnitedHealthcare provided a $275,000 grant to the American Heart Association to support food access and nutrition in all four tribes located in Kansas. The expanded program will incorporate Food as Medicine to drive improved health outcomes through culturally tailored best practices.

Kansans United

United Healthcare Community Plan

Experience and Qualifications

1. Describe the bidder's Medicaid Managed Care experience in the past five (5) years by completing a table that includes the information listed below for each contract.

a. Name of state and program name.

b. Start and end date.

c. Services covered under the contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation).

d. Covered population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children.

e. Average number of total member months for the most recent twelve (12) months of the contract (or most recent period if the contract has been in place less than twelve [12] months).

f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance.

g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed.

UnitedHealthcare's Medicaid Managed Care Experience – Past Five Years

Table 1. Experience and Qualifications (1 of 43)

Kansas	
a. State/Program name.	Kansas/KanCare Managed Care 2.0
b. Start and end date.	Contract Origination Date: 1/1/2013 Current Contract: 1/1/2019 – 12/31/2024
c. Services covered under the contract.	All covered services, including standard Medicaid benefit package for physical health, behavioral health, pharmacy, transportation, dental, vision services, home- and community-based services (HCBS), long-term services and supports (LTSS) for Members with autism, severe emotional disturbance, technology assisted, brain injury, frail elderly, physically disabled, individuals with intellectual or developmental disabilities (IDD) and AIDS drug assistance programs.

Kansas	
	High-risk foster children are managed via case management. IDD waiver Members receive case management and HCBS, including personal care services, day services, residential services and other services.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Dual Eligible Individuals, Aged, Blind and Disabled (ABD), Children's Health Insurance Program (CHIP), Long-Term Care (LTC), Individuals with Intellectual or Developmental Disabilities (IDD), Temporary Assistance for Needy Families (TANF) and individuals receiving Supplemental Security Income (SSI) with or without Medicare, including Foster Care (FC) populations. Covered populations with waivers include Frail Elderly (FE), Physical Disability (PD), Autism, Severe Emotional Disturbance (SED), Individuals with Intellectual or Developmental Disabilities (IDD), Brain Injury (BI) and Technology Assisted (TA).
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 2,077,851 Average Members per Month: 173,154
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	For subcontractors performing delegated Managed Care functions, UnitedHealthcare closely monitors the subcontractors' performance to make sure it is no less effective than our performance. We ensure the terms of subcontracts are the same terms and conditions of the contracts existing between UnitedHealthcare and state entities, including Kansas Department of Health and Environment (KDHE), for the provision of covered services. We put in place service level agreements or statements of work for each of our subcontracted entities, and subcontractors provide reports that validate their compliance with each element of the contract. Accuracy and applicability of reports and data elements occur either as part our oversight for subcontractors, or at the time of any designated external quality review organization (EQRO) or other State data audits, as most appropriate. Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services

Kansas	
	▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — behavioral health ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ Modivcare Solutions, LLC — nonemergency medical transportation services ▪ Pediatric Care Network (PCN) — delegated medical management, including utilization management, disease management and case management for physical health

Table 2. Experience and Qualifications (2 of 43)

Arizona (Contract 1 of 3)	
a. State/Program name.	Arizona/Arizona Health Care Cost Containment System (AHCCCS) – AHCCCS Complete Care
b. Start and end date.	Contract Origination Date: 10/1/1982 Current Contract: 10/1/2018 – 9/30/2027
c. Services covered under the contract.	All covered services, including standard Medicaid benefit package for physical health, behavioral health, pharmacy, transportation services to all covered services, dental, vision services, home- and community-based services (HCBS) and HIV/AIDS Specialty Plan Services.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Dual Eligible Individuals, Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), Serious Mental Illness (SMI), and Expansion populations, including individuals receiving Supplemental Security Income (SSI) with or without Medicare, and Children & Youth with Special Health Care Needs (CYSHCN).
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 5,595,519 Average Members per Month: 466,293
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.

Arizona (Contract 1 of 3)	
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — behavioral health services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Medical Transportation Brokerage of Arizona — nonemergency medical transportation services ▪ SightCare/Nationwide Vision — vision care services

Table 3. Experience and Qualifications (3 of 43)

Arizona (Contract 2 of 3)	
a. State/Program name.	Arizona/Arizona Long-Term Care System for Elderly and Physically Disabled (ALTCS-EPD)
b. Start and end date.	Contract Origination Date: 1/1/1989 Current Contract: 10/1/2017 – 9/30/2024
c. Services covered under the contract.	All covered services, including standard Medicaid benefit package for physical health, Individuals with Intellectual or Developmental Disabilities (IDD), behavioral health, pharmacy, transportation services to all covered services, dental, vision services, long-term services and supports (LTSS) and home- and community-based services (HCBS).
d. Covered population(s).	Adults, Long-Term Care (LTC) populations — all ages, Aged, Blind and Disabled (ABD), Individuals with Intellectual or Developmental Disabilities (IDD). This program provides coverage to certain elderly, physically disabled and chronically ill Medicaid populations in Arizona based on income criteria and Activities of Daily Living (ADLs).
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 102,233 Average Members per Month: 8,519
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.

Arizona (Contract 2 of 3)	
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — behavioral health services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Medical Transportation Brokerage of Arizona — nonemergency medical transportation services ▪ SightCare/Nationwide Vision — vision care services

Table 4. Experience and Qualifications (4 of 43)

Arizona (Contract 3 of 3)	
a. State/Program name.	Arizona/Arizona Long-Term Care System for Developmental Disabilities (ALTCS-DD)
b. Start and end date.	Contract Origination Date: 12/19/1988 Current Contract: 10/1/2019 – 9/30/2029
c. Services covered under the contract.	All covered services, including physical health benefits, Individuals with Intellectual or Developmental Disabilities (IDD), pharmacy, behavioral health benefits, including inpatient, outpatient, residential programs and applied behavioral analysis; dental services, including children, adults and individuals living in intermediate care facilities; transportation services to all covered services; vision services, including exams, treatment and hardware; and a number of long-term support services, including augmentative communication evaluations and devices, habilitative physical therapy for adults, custodial nursing facilities and personal emergency response systems and home- and community-based services (HCBS).

Arizona (Contract 3 of 3)	
	Foster Care (FC) services apply to Individuals with Intellectual or Developmental Disabilities (IDD), FC with IDD, and children with special health care needs. Services include acute and primary care, including, audiology, augmentative communication devices, birthing services, cancer screening and treatment, chiropractic, dialysis, durable medical equipment (DME), early childhood intervention (ECI) service, family planning, home health care, laboratory, medical checkups and care for children under age 21, oral evaluation and fluoride varnish for Members six months to 35 months of age, vision, pharmacy benefits, podiatry, prenatal care, preventive services, radiology, therapies, transportation, transplant and other specialty services. We cover behavioral health services, including counseling, therapy, applied behavioral analysis, peer supports, substance use recovery, residential, post-crisis stabilization and medication management.
d. Covered population(s).	Adults, Children (aged 0–18), Individuals with Intellectual or Developmental Disabilities (IDD), Dual Eligible Individuals, Foster Care (FC), Children & Youth with Special Health Care Needs (CYSHCN). This program provides coverage to residents who have chronic disabilities attributable to mental developmental disabilities, cerebral palsy, epilepsy, or autism manifested prior to age 18. Children under age 6 may be eligible for services, if it is demonstrated that the child is or will become developmentally disabled. Members must be enrolled in ALTCS, which is part of AHCCCS.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 278,424 Average Members per Month: 23,202
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — behavioral health services

Arizona (Contract 3 of 3)	
	▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Medical Transportation Brokerage of Arizona — nonemergency medical transportation services ▪ SightCare/Nationwide Vision — vision care services

Table 5. Experience and Qualifications (5 of 43)

California	
a. State/Program name.	California/Medi-Cal Managed Care
b. Start and end date.	Contract Origination Date: 10/1/2017 Most Recent Contract: 10/1/2017 – 12/31/2022
c. Services covered under the contract.	All covered services, including standard Medicaid benefit package for physical health, behavioral health, transportation, and vision services; transplant services and enhanced care management services added in 2022.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Children's Health Insurance Program (CHIP), Expansion, Individuals with Intellectual or Developmental Disabilities (IDD), Aged, Blind and Disabled (ABD), Dual Eligible, Long-Term Care (LTC), Supplemental Security Income (SSI) with or without Medicare, and Temporary Assistance for Needy Families (TANF) populations.
e. Average number of total member months.	Membership from Jan. 1, 2022 – Dec. 31, 2022: Total Member Months: 354,598 Average Members per Month: 29,550
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management

California	
	▪ United Behavioral Health, Inc. (operating under the brand name Optum) — behavioral health services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Modivcare Solutions, LLC — nonemergency medical transportation services

Table 6. Experience and Qualifications (6 of 43)

Colorado (Contract 1 of 2)	
a. State/Program name.	Colorado/Health First Colorado
b. Start and end date.	Contract Origination Date: 7/1/1975 Current Contract: 7/1/2018 – 6/30/2025, with seven-year procurement with annual renewals.
c. Services covered under the contract.	All covered services, including standard Medicaid benefit package for physical health, behavioral health, dental, pharmacy, transportation, and vision services. Rocky Mountain Health Plans (RMHP) provides long-term services and supports (LTSS) Case Management Agency (CMA) services for over 5,000 home- and community-based services (HCBS) clients, fulfilling ADL assessments, case management planning, critical incident response, client directed services, caregiver supports and Provider coordination. Children and youth in foster care settings are enrolled in the Regional Accountable Entities (RAEs). RMHP supports a variety of Children and Youth wraparound and treatment programs, under a separate agreement with the Colorado Behavioral Health Administration.
d. Covered population(s).	Adults, Pregnant, Children (aged 0-18), Children's Health Insurance Program (CHIP), Newborn, Foster Care (FC), Individuals with Intellectual or Developmental Disabilities (IDD), Aged, Blind and Disabled (ABD), Dual eligible individuals. Within Colorado's regional program structure, we operate the following MCO contracts: ▪ RMHP Prime is available to Health First Colorado members who are adults or children with disabilities, including Adoption Assistance (AA), Children & Youth with Special Health Care

Colorado (Contract 1 of 2)	
	Needs (CYSHCN), Foster Care (FC), Former Foster Youth (FFY) and Juvenile Justice System (JJS), Expansion, Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI) with or without Medicare. ▪ RMHP CHP+ is the state's Children's Health Insurance Program (CHIP) populations. ▪ HCBS and other LTSS eligible populations (including Aged, Blind and Disabled [ABD], Individuals with Intellectual or Developmental Disabilities [IDD]) are enrolled in the Colorado RAE program, and RMHP MCO agreements.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 740,243 Average Members per Month: 61,687
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ OptumRx, Inc. — pharmacy benefit management Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services

Table 7. Experience and Qualifications (7 of 43)

Colorado (Contract 2 of 2)	
a. State/Program name.	Colorado/Colorado Behavioral Health Administration – Administrative Services Organization (ASO)
b. Start and end date.	Contract Origination Date: 7/1/2019 Current ASO Contract: 7/1/2019 – 6/30/2024, with five-year procurement with annual renewals.
c. Services covered under the contract.	Medical, Behavioral, Pharmacy, Crisis response, high-fidelity wraparound services for children and youth, child welfare assessments and coordination, substance use disorder treatment services. NOTE: The Colorado ASOs are responsible for service capacity and coordination for all residents within their assigned geographies, regardless of Medicaid or other coverage types.

Colorado (Contract 2 of 2)	
	Services covered by Medicaid, Medicare or commercial service are netted by the ASOs from direct funding paid by the state. Home- and community-based services (HCBS) and other Long-Term Care (LTC) eligible populations, including Aged, Blind and Disabled (ABD), Individuals with Intellectual or Developmental Disabilities (IDD) are enrolled in the Colorado RAE program, and RMHP MCO agreements. RMHP provides long-term services and supports (LTSS) CMA services for over 5,000 HCBS clients, fulfilling ADL assessments, case management planning, critical incident response, client directed services, caregiver supports and Provider coordination. Children and youth in foster care settings are enrolled in the RAE. RMHP supports a variety of Children and Youth wraparound and treatment programs, under a separate agreement with the Colorado Behavioral Health Administration.
d. Covered population(s).	Adults, Pregnant, (Medicaid Children (aged 0-18), Newborn, Foster Care, Adoption Assistance and/or Justice-involved youth, Individuals with Intellectual or Developmental Disabilities, ABD, Dual eligible individuals.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 2,313,155 Average Members per Month: 192,763
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Non-Affiliate: ▪ Signal Behavioral Health Network — behavioral health services

Table 8. Experience and Qualifications (8 of 43)

District of Columbia	
a. State/Program name.	District of Columbia/District Dual Choice
b. Start and end date.	Contract Origination Date: 2/1/2022 Current Contract: 2/1/2022 – 12/31/2026, with one-year renewal opportunities.

District of Columbia	
c. Services covered under the contract.	The District Dual Choice program is designed to establish a coordinated and integrated health care service delivery system for individuals who are eligible and enrolled in Medicare and Medicaid programs. The District Dual Choice program includes all services covered by Medicare and Medicaid, including long-term services and supports (LTSS), including home- and community-based services (HCBS), and nursing facility services, pharmacy and behavioral health services. Contract includes all dually eligible individuals in the district, including those requiring all types of community-based or nursing facility long-term care services. LTSS for individuals with intellectual and developmental disabilities are not included in the program.
d. Covered population(s).	Adults, Pregnant, Dual eligible individuals, covers individuals who are 21 years of age or older, who receive both Medicare (Parts A, B and D) and Medicaid coverage.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 168,689 Average Members per Month: 14,057
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ LifePrint — clinical care coordination ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — behavioral health Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Modivcare Solutions, LLC — nonemergency medical transportation services

Table 9. Experience and Qualifications (9 of 43)

Florida	
a. State/Program name.	Florida/Statewide Medicaid Managed Care (SMMC)
b. Start and end date.	Contract Origination Date: 8/1/2013 Current Contract: 12/1/2018 – 12/31/2024
c. Services covered under the contract.	All covered services, including standard and expanded value-added Medicaid benefit package for physical health, behavioral health, home- and community-based services (HCBS), pharmacy, transportation, vision and long-term services and supports (LTSS). LTSS are provided to individuals aged 21 and older. This population includes individuals who are comprehensive (receive Medicaid services) and are dual eligible Medicare Members.
d. Covered population(s).	Adult, Pregnant, Children (aged 0–18), Newborn, Temporary Assistance for Needy Families (TANF) populations, Long-Term Care (LTC), Aged, Blind and Disabled (ABD), Individuals receiving Supplemental Security Income (SSI) without Medicare, Supplemental Security Income (SSI) with Medicare primary, Foster Care (FC), Child Welfare, HIV/AIDS, Serious Mental Illness (SMI), and Dual Eligible Special Needs populations. NOTE: Individuals with Intellectual or Developmental Disabilities (IDD) are covered under a separate program.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 4,710,446 Average Members per Month: 392,537
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ March® Vision Care Group, Incorporated — utilization management, network management ▪ OptumInsight, Inc. — fraud, abuse and/or overpayment (F&A) services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — behavioral health (BH) services, utilization

Florida	
	management, Provider credentialing and contracting, network development, claims payment ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ Aperture Credentialing, LLC — credentialing ▪ BeneLynk— care coordination, case management ▪ Careforth (formerly Seniorlink, Inc.) — care coordination, case management ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Florida Care Management Services Agency, Inc. — care coordination ▪ Health Choice Network — Provider credentialing and contracting ▪ JMG Specialty Physicians — Provider credentialing and contracting ▪ MEDNAX Services Inc. (formerly known as Pediatrix Medical Group) — Provider credentialing and contracting ▪ MedZed, LLC — case management, care coordination ▪ Modivcare Solutions, LLC — nonemergency medical transportation services ▪ Nemours Children's Clinic — Provider credentialing and contracting ▪ OTC Health Solutions (Navarro) — pharmacy benefits manager, Provider credentialing and contracting, network development ▪ Orlando Regional Hospital — Provider credentialing and contracting ▪ Pediatric Associates — Provider credentialing and contracting ▪ Reema Health, Inc. — care coordination ▪ Shands Teaching Hospital and Clinic — Provider credentialing and contracting ▪ Unite Us — care coordination, case management ▪ University of Miami Medical Group — Provider credentialing and contracting ▪ Variety Children's Hospital (d.b.a. Miami Children's Hospital) — Provider credentialing and contracting

Table 10. Experience and Qualifications (10 of 43)

Hawaii	
a. State/Program name.	Hawaii/QUEST Integration
b. Start and end date.	Contract Origination Date: 1/1/2015 Current Contract: 7/1/2021 – 12/31/2026, with up to 3 (1) year extensions at discretion of State of Hawaii.

Hawaii	
	We covered the ABD/LTSS populations under Quest Expanded Access from 2/1/2009 – 12/31/2014 and served all other Medicaid under Quest from 7/1/2012 – 12/31/2014.
c. Services covered under the contract.	All covered services, including standard Medicaid benefit package for physical health, BH, pharmacy, long-term services and supports (LTSS), transportation and vision; includes additional services for home- and community-based services (HCBS), housing coordination, home modifications, and field-based care management for specific cohorts. Behavioral health services for the serious mental illness/serious and persistent mental illness (SMI/SPMI) population are carved out, as well as certain services provided by the state of Hawaii directly, including for the Individuals with Intellectual or Developmental Disabilities (IDD) population, Induced Termination of Pregnancy (ITOP), certain transplants and dental services. Additional value-added services include respite care, community transitions (those exiting the correctional system) and peer support services for those recovering from substance use addiction. Full care coordination, call center support and other coordinated activities for dual eligible are enrolled in both our Medicaid and MA-Dual Special Needs Plan (D-SNP) programs. NOTE: We cover all children in State custody/under State supervision except for services provided by the Department of Health to the IDD population, BH services for such children who have serious mental illness/serious and persistent mental illness (SMI/SPMI), and children in the State juvenile detention center. All Medicaid-enrolled individuals receiving nursing facility level of care in an inpatient medical facility or residing in an assisted living facility, expanded adult care home, community care foster family home, nursing facility or sub-acute setting. We have as a “value-added service” our “Community Transitions” program, which assists of those coming out of the prison system. “Community Transitions” is only for adults, but it could support a child coming out of the juvenile detention system.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Aged, Blind and Disabled (ABD), Children’s Health Insurance Program (CHIP), Dual Eligible, Expansion, Long-Term Care (LTC) and Temporary Assistance for Needy Families (TANF) populations, including Adoption Assistance (AA), Children & Youth with Special Health Care Needs (CYSHCN), Foster Care (FC), Former

Hawaii	
	Foster Youth (FFY) and Juvenile Justice System (JJS) populations.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 724,270 Average Members per Month: 60,356
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ CCMAs — 21 (and one pending) independent case management agencies as required by Hawaii statute for delegated care coordination for Medicaid Members in adult foster homes receiving long-term care ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ MDX Hawaii, Inc. — Credentialing for all Providers in Hawaii except BH Providers, pharmacies, long-term services and supports (LTSS)/home- and community-based services (HCBS) Providers and nationally contracted Providers ▪ Modivcare Solutions, LLC — nonemergency medical transportation services

Table 11. Experience and Qualifications (11 of 43)

Indiana	
a. State/Program name.	Indiana/Hoosier Care Connect (HCC)
b. Start and end date.	Contract Origination Date: 4/1/2021 Current Contract: 4/1/2021 – 3/31/2025 NOTE: New contract starts Jan. 1, 2024 – Dec. 31, 2028, with two, one-year renewal options.

Indiana	
c. Services covered under the contract.	All covered services, including standard Medicaid benefit package for physical health, BH, pharmacy, transportation, dental and vision services. Members in foster care have the option to select a managed care entity (MCE). One-fourth of our HCC population are Members in foster care.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Aged, Blind and Disabled (ABD), and individuals receiving Supplemental Security Income (SSI) without Medicare, Foster Care (FC). NOTE: Individuals with Intellectual or Developmental Disabilities (IDD) is a separate waiver type.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 70,569 Average Members per Month: 5,881
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliate: Minority, Women and Veterans' Subcontractors: ▪ LCP Transportation, LLC — Provides nonemergency medical passenger transport

Table 12. Experience and Qualifications (12 of 43)

Iowa	
a. State/Program name.	Iowa/Iowa Health Link (Medicaid)
b. Start and end date.	Contract Origination Date: 4/1/2016 Most Recent Contract: 4/1/2016 – 6/30/2019

Iowa	
c. Services covered under the contract.	All covered services, including standard Medicaid benefit package for physical health, long-term services and supports (LTSS), BH, pharmacy, transportation, home- and community-based services (HCBS) for eight waivers (brain injury, intellectual disability, physical disability, HIV/AIDS, elderly, children's mental health, health and disability, and habilitation), dental, vision services and nonemergent transportation. The contract covered children and youth with medical complexity. Types of services include preventive services such as routine checkups and immunizations, professional office services, including adult and child office visits, BH, chiropractic, dental and vision visits, hospital services and ambulatory surgery centers, emergency care, including ambulance, behavioral health treatment, Outpatient (OP) Therapy services, including Physical Therapy (PT)/Occupational Therapy (OT)/Speech Therapy (ST), cardiac and respiratory, pharmacy, radiology and lab services, durable medical equipment (DME), LTSS community-based and institutional services, hospice care and health homes.
d. Covered population(s).	Children's Health Insurance Program (CHIP), Expansion, Dual Eligible Medicaid for Employed People with Disabilities, Long-Term Care (LTC), Supplemental Security Income (SSI) and Temporary Assistance for Needy Families (TANF) populations, including Adoption Assistance (AA), Children & Youth with Special Health Care Needs (CYSHCN), Foster Care (FC), Former Foster Youth (FFY) and Juvenile Justice System (JJS) populations.
e. Average number of total member months.	Membership from July 1, 2018 – June 30, 2019: Total Member Months: 5,026,417 Average Members per Month: 418,868
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services

Iowa	
	Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Medical Transportation Management Inc. — nonemergency medical transportation services ▪ Superior Vision — vision care services

Table 13. Experience and Qualifications (13 of 43)

Kentucky	
a. State/Program name.	Kentucky/Kentucky Medicaid and KCHIP
b. Start and end date.	Contract Origination Date: 1/1/2021 Current Contract: 1/1/2021 – 12/31/2024, with renewal options at the completion of the initial contract period for six additional two-year periods upon the mutual agreement of the parties.
c. Services covered under the contract.	All covered services, including standard Medicaid benefit package for physical health, BH, dental and vision services, including durable medical equipment (DME). Long-term services and supports (LTSS) is in the fee-for-service program in Kentucky and is not managed by MCOs.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Dual Eligible Individuals, Children's Health Insurance Program (CHIP), Aged, Blind and Disabled (ABD), Individuals with Intellectual or Developmental Disabilities (IDD), Expansion, Temporary Assistance for Needy Families (TANF) populations, including individuals receiving Supplemental Security Income (SSI) with or without Medicare.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 1,172,033 Average Members per Month: 97,669
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management,

Kentucky	
	payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ Modivcare Solutions, LLC — nonemergency medical transportation services

Table 14. Experience and Qualifications (14 of 43)

Louisiana	
a. State/Program name.	Louisiana/Healthy Louisiana
b. Start and end date.	Contract Origination Date: 1/1/2012 Current Contract: 1/1/2023 – 12/31/2025, with an option to extend up to two more years.
c. Services covered under the contract.	All covered services, including standard Medicaid benefit package for physical health, BH, pharmacy, transportation, dental, vision services, home- and community-based services (HCBS), long-term services and supports (LTSS) for Members with autism, SED, technology assisted, brain injury, frail elderly, physically disabled, Individuals with Intellectual or Developmental Disabilities (IDD) and AIDS drug assistance programs. Our high-risk case management team provides full case management to foster care Members who come into the system through referral.
d. Covered population(s).	Children (aged 0–18), Newborn, Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP), Aged, Blind and Disabled (ABD), Individuals with Intellectual or Development Disabilities (IDD), Dual Eligible Individuals, pregnant Members, adults, older adults, children and adults with disabilities (Supplemental Security Income [SSI] without Medicare), expansion, foster care and juvenile justice, Department of Corrections, several waiver programs. This contract covers the following populations — youth aging out of foster care (i.e., children under 21 who were in foster care and covered by Medicaid on their 18th birthdays), former foster care children (i.e., Members aged 18 through 26 who were receiving Medicaid benefits and in foster care at the time they reached 18), and foster care children (i.e., Medicaid beneficiaries who are

Louisiana	
	receiving foster care or adoption assistance [Title IV-E], are in foster care, or are in an out-of-home placement).
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 5,728,258 Average Members per Month: 477,355
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Modivcare Solutions, LLC — nonemergency medical transportation services

Table 15. Experience and Qualifications (15 of 43)

Maryland	
a. State/Program name.	Maryland/HealthChoice
b. Start and end date.	Contract Origination Date: 1/1/2000 Current Contract: 1/1/2021 – 12/31/2023, with annual renewal options indefinitely.
c. Services covered under the contract.	All covered services, including standard Medicaid benefit package for physical health, pharmacy, vision services, occupational, physical and speech therapy, speech augmentation services, medical day care, nursing facility and certain HIV/AIDS diagnostic services.

Maryland	
	NOTE: People over age 65, duals and Individuals with Intellectual or Developmental Disabilities (IDD) are carved out. For BH, the Member is enrolled in HealthChoice for medical services, but the BH and substance use services are in fee-for-service (FFS). Dental, transportation and long-term services and supports (LTSS) are provided via FFS. We serve foster children in HealthChoice. We have a special needs coordinator who works with the county Department of Social Services to provide needed support for foster care children.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Aged, Blind and Disabled (ABD), Dual Eligible Individuals, Expansion, Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), including Children & Youth with Special Health Care Needs (CYSHCN), Foster Care (FC), Former Foster Youth (FFY).
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 2,090,864 Average Members per Month: 174,239
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ Aperture Credentialing, LLC — credentialing ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Medical Transportation Management, Inc. — nonemergency medical transportation services

Table 16. Experience and Qualifications (16 of 43)

Massachusetts (Contract 1 of 2)	
a. State/Program name.	Massachusetts/Senior Care Options (SCO)
b. Start and end date.	Contract Origination Date: 1/1/2009 Current Contract: 1/1/2016 – 12/31/2024, contract may be extended in one-year increments through Dec. 31, 2025.
c. Services covered under the contract.	All covered services under the FIDE-SNP, including Medicare benefits and standard Medicaid benefit package for physical health, BH, dental, pharmacy, transportation and vision services, long-term services and supports (LTSS) and home- and community-based services (HCBS). Services are offered to those age 65 or older, eligible for MassHealth Standard, living at home or in a long-term care facility (Member cannot be an inpatient at a chronic or rehabilitation hospital or reside in an intermediate care facility for people with intellectual disabilities), not subject to a six-month deductible period under MassHealth regulations, and live in an area served by a SCO plan.
d. Covered population(s).	Adults, Long-Term Care (LTC), Expansion, Dual Eligible Individuals.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 295,260 Average Members per Month: 24,605
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ Spectera United Healthcare Vision — vision care services ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates:

Massachusetts (Contract 1 of 2)	
	▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Modivcare Solutions, LLC — nonemergency medical transportation services

Table 17. Experience and Qualifications (17 of 43)

Massachusetts (Contract 2 of 2)	
a. State/Program name.	Massachusetts/One Care Medicare-Medicaid Plan (MMP)
b. Start and end date.	Contract Origination Date: 1/1/2022 Current Contract: 1/1/2022 – 12/31/2024, with opportunities to renew or negotiate amendments through Dec. 31, 2025.
c. Services covered under the contract.	All covered services, including Medicare benefits and the standard Medicaid benefit package for physical health, BH, dental, pharmacy, transportation, vision services and long-term services and supports (LTSS).
d. Covered population(s).	Adults with physical disabilities, disabilities due to Serious Mental Illness (SMI), Substance Use Disorders (SUDs), Intellectual or Developmental Disabilities (IDD) who are Dual Eligible Individuals. NOTE: Members must live in designated service areas (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it) and have both Medicare Part A and Medicare Part B and are eligible for Part D; are eligible for MassHealth Standard or MassHealth CommonHealth and are between the ages of 21 and 64 to initially enroll; are a United States citizen or are lawfully present in the United States; are not enrolled in a MassHealth home- and community-based services (HCBS) waiver; and have no other health insurance.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 44,049 Average Members per Month: 3,671
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services

Massachusetts (Contract 2 of 2)	
functions and functions performed.	▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ Spectera United Healthcare Vision — vision care services ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United Healthcare Hearing — hearing aid administration dispensing services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Modivcare Solutions, LLC — nonemergency medical transportation services

Table 18. Experience and Qualifications (18 of 43)

Michigan	
a. State/Program name.	Michigan/Michigan Medicaid
b. Start and end date.	Contract Origination Date: 10/1/2011 Current Contract: 1/1/2016 – 9/30/2024
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for physical health, outpatient BH, dental services for two Medicaid categories, pharmacy, transportation and vision services. We provide comprehensive case management and care coordination services to any child in foster care and former foster care youth.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Child Rehabilitation Services (CRS), Expansion, Dual Eligible Individuals, Aged, Blind and Disabled (ABD), Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF) and individuals receiving Supplemental Security Income (SSI) with or without Medicare, including Adoption Assistance (AA), Children & Youth with Special Health Care Needs (CYSHCN), Foster Care (FC), Former Foster Youth (FFY) and Juvenile Justice System (JJS) populations.

Michigan	
	Note: Individuals with Intellectual or Developmental Disabilities (IDD) is not covered under this contract.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 3,698,972 Average Members per Month: 308,248
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Modivcare Solutions, LLC — nonemergency medical transportation services

Table 19. Experience and Qualifications (19 of 43)

Minnesota (Contract 1 of 3)	
a. State/Program name.	Minnesota/Minnesota Families and Children Medical Assistance (Prepaid Medical Assistance Program – PMAP) and MinnesotaCare NOTE: MinnesotaCare is designated as a Basic Health Plan (BHP).
b. Start and end date.	Contract Origination Date: 1/1/2022 Current Contract: 1/1/2023 – 12/31/2023, with annual renewals for up to five years.

Minnesota (Contract 1 of 3)	
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for physical health, BH, dental, pharmacy, transportation and vision services; state-approved value-added benefits MCOs offer and administer are included. This population does not qualify for long-term services and supports (LTSS). Our specialty services provide primarily mental health services to the Minnesota Families and Children Medical Assistance (Prepaid Medical Assistance or PMAP) populations.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF) and Expansion populations, including additional populations covered under the BHP. Minnesota received BHP designation from CMS, which enables the state to offer Medicaid to a greater portion of residents who did not qualify previously. Covered child and youth populations include Adoption Assistance (AA), Children & Youth with Special Health Care Needs (CYSHCN), Foster Care (FC), Former Foster Youth (FFY) and Juvenile Justice System (JJS).
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 453,140 Average Members per Month: 37,762
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates:

Minnesota (Contract 1 of 3)	
	▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Medical Transportation Management Inc. — nonemergency medical transportation services

Table 20. Experience and Qualifications (20 of 43)

Minnesota (Contract 2 of 3)	
a. State/Program name.	Minnesota/Special Needs BasicCare Program Services for People with Disabilities (SNBC)
b. Start and end date.	Contract Origination Date: 1/1/2023 Current Contract: 1/1/2023 – 12/31/2023
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for physical health, BH, dental, pharmacy, transportation and vision services; state-approved value-added benefits MCOs offer and administer are included. The health plan offers a highly integrated D-SNP (HIDE D-SNP) plan for the special needs population. The Special Needs BasicCare Plan covers individuals ages 18 to 64.
d. Covered population(s).	Adults, Pregnant, ages 18 to 64, Dual Eligible Individuals, Individuals with Intellectual or Developmental Disabilities (IDD), certified disabled individuals eligible for Medical Assistance (Medicaid) and/or qualify for Medical Assistance and Medicare Parts A and B (dual eligible), through Social Security Administration (SSA) or State Medical Review Team (SMRT); or has a developmental disability and receives services through a Developmental Disability Waiver, administered through a local agency (county).
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 2,539 Average Members per Month: 212
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services

Minnesota (Contract 2 of 3)	
	▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Medical Transportation Management Inc. — nonemergency medical transportation services

Table 21. Experience and Qualifications (21 of 43)

Minnesota (Contract 3 of 3)	
a. State/Program name.	Minnesota/Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus Services (MSC+)
b. Start and end date.	Contract Origination Date: 1/1/2023 Current Contract: 1/1/2023 – 12/31/2023
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for physical health, BH, dental, pharmacy, transportation and vision services; state-approved value-added benefits MCOs offer and administer are included. For seniors, long-term services and supports (LTSS) and home- and community-based services (HCBS) (Elderly Waiver) are covered benefits.
d. Covered population(s).	Seniors (age 65 and older) covered under dual special needs plan (MSHO) and/or Medical Assistance (Medicaid) (MSC+), Aged, Blind and Disabled (ABD), Individuals with Intellectual or Developmental Disabilities (IDD), and Dual Eligible Individuals who qualify for Long-Term Care (LTC) and home- and community-based services (HCBS).
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 306 Average Members per Month: 26
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.

Minnesota (Contract 3 of 3)	
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Medical Transportation Management Inc. — nonemergency medical transportation services

Table 22. Experience and Qualifications (22 of 43)

Mississippi (Contract 1 of 2)	
a. State/Program name.	Mississippi/MississippiCAN
b. Start and end date.	Contract Origination Date: 7/1/2011 Current Contract: 7/1/2023 – 6/30/2024
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for physical health, BH, dental, pharmacy, transportation and vision services. This program provides statewide health care coverage throughout Mississippi for Children's Health Insurance Program (CHIP), Supplemental Security Income (SSI) and Temporary Assistance for Needy Families (TANF) Members of the Medicaid population. General types of services covered include medical, BH, dental, vision and nonemergent transportation. Care managers (e.g., RNs, community outreach and BH clinicians) deliver hands-on care management, including risk assessments and individualized plans of care with monitoring and oversight. Enrollment is mandatory for most populations. Enrollment is

Mississippi (Contract 1 of 2)	
	voluntary for American Indians. The Medicaid contract is integrated with BH and transportation.
d. Covered population(s).	Adults, Children (aged 0–18), Newborn, Dual Eligible Individuals, Aged, Blind and Disabled (ABD), Individuals with Intellectual or Developmental Disabilities (IDD), Temporary Assistance for Needy Families (TANF), women who are pregnant, individuals receiving services for breast or cervical cancer, individuals who are disabled and working, and individuals receiving Supplemental Security Income (SSI) without Medicare, including Adoption Assistance (AA), Children & Youth with Special Health Care Needs (CYSHCN), Foster Care (FC).
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 1,816,729 Average Members per Month: 151,394
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Medical Transportation Management Inc. — nonemergency medical transportation services

Table 23. Experience and Qualifications (23 of 43)

Mississippi (Contract 2 of 2)	
a. State/Program name.	Mississippi/Mississippi CHIP

Mississippi (Contract 2 of 2)	
b. Start and end date.	Contract Origination Date: 7/1/2010 Current Contract: 8/1/2023 – 7/31/2024
c. Services covered under the contract.	All covered services in the standard Children's Health Insurance Program (CHIP) benefit package for physical health, BH, dental, pharmacy, transportation and vision service.
d. Covered population(s).	Children's Health Insurance Program (CHIP)
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 327,896 Average Members per Month: 27,325
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Medical Transportation Management Inc. — nonemergency medical transportation services

Table 24. Experience and Qualifications (24 of 43)

Missouri	
a. State/Program name.	Missouri/Missouri HealthNet
b. Start and end date.	Contract Origination Date: 5/1/2017 Current Contract: 7/1/2023 – 6/30/2024, with four, one-year renewals
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for physical health, BH, dental, transportation, vision and long-term

Missouri	
	services and supports (LTSS), including private duty nursing (PDN) and personal care services (PCS) and home- and community-based services (HCBS). We have dual Members who are not in Medicaid and integrated. We do not manage the Medicaid and Medicare benefits of a dual. NOTE: Foster Care (FC), Juvenile Justice System (JJS), Adoption Assistance (AA), Individuals with Intellectual or Developmental Disabilities (IDD), Former Foster Youth (FFY), and Children & Youth with Special Health Care Needs (CYSHCN) were part of our contract with Missouri HealthNet from May 2017 – June 2022. Populations were carved out of the overall Managed Care contract to a sole source contract effective July 1, 2022. We provided specialized care management services to children in foster care, receiving adoption assistance and in the custody of the juvenile justice system. We provided specialized care management to former foster youth (i.e., 18- to 26-year-olds who have transitioned out of the foster care system; this group receives the same Medicaid benefits as Members in foster care due to their previous status in the child welfare system. These children and young adults were managed by a specialized team of fully licensed care managers over 250 years of mostly lived child welfare experience.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Children's Health Insurance Program (CHIP), Dual Eligible Individuals, Expansion, and Temporary Assistance for Needy Families (TANF).
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 4,167,831 Average Members per Month: 347,319
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management,

Missouri	
	payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Medical Transportation Management Inc. — nonemergency medical transportation services ▪ Pediatric Care Network (PCN) — delegated medical management, including utilization management, disease management and case management for physical health

Table 25. Experience and Qualifications (25 of 43)

Nebraska	
a. State/Program name.	Nebraska/Nebraska Heritage Health
b. Start and end date.	Contract Origination Date: 1/1/1996 Current Contract: 1/1/2017 – 12/31/2023 NOTE: New contract starts Jan. 1, 2024 – Dec. 31, 2029, with two, one-year renewal options.
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for physical health, BH, pharmacy, transportation and vision services. NOTE: We provide a level of case management and coordination that is atypical for not having long-term services and supports (LTSS) as a carved in service. For direct adoption assistance, we case manage subsidized adoptions and subsidize guardianships that are subsidized through the state as part of our Ward's (Children and Adolescents actively involved with Child and Family Services, Foster Care, Children and Adolescents who are in a subsidized adoption or subsidized guardianship) population. We case manage (acute care, not LTSS care plans) all waiver members and provide everything to them except for home- and community-based services (HCBS) or residential nursing facility claims. The LTSS waiver populations in Nebraska include Aged and Disabled, Comprehensive Developmental Disability, Development Disabilities Adult Day Waiver and the Traumatic Brain Injury Waiver.

Nebraska	
	Transition age youth are a focus, and for former wards, we provide ongoing support through case management addressing the same needs, medical, BH, pharmacy, durable medical equipment (DME) and social determinants of health (SDOH) all with a trauma-informed approach designed to meet them where they are. For Juvenile Justice System (JJS), we do not have case management while someone is actively incarcerated, and the state does not have a rate cell for juvenile justice involved. We provide case management to many juveniles who are in various stages of juvenile justice and will coordinate case management reviews with probation officers where warranted. We are aware that children in foster care need system innovation, systemic change and streamlined processes to achieve permanency and lead healthy lives. To support this, we coordinate and manage all service types independent of state funding source, such as physical health, BH, parenting programs, visitation services, substance use treatment and transportation services.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Aged, Blind and Disabled (ABD), Individuals with Intellectual or Developmental Disabilities (IDD), Children's Health Insurance Program (CHIP), Dual Eligible, Expansion, Long-Term Care (LTC), Supplemental Security Income (SSI) without Medicare, refugee and Temporary Assistance for Needy Families (TANF), including Adoption Assistance (AA), Children & Youth with Special Health Care Needs (CYSHCN), Foster Care (FC), Former Foster Youth (FFY) and Juvenile Justice System (JJS) populations.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 1,577,464 Average Members per Month: 131,455
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services

Nebraska	
	▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ Advize Health, L.L.C. — payment integrity services ▪ Care Angel, Inc. — care management support services ▪ Eventa, LLC — delegated utilization management services ▪ Modivcare Solutions, LLC — nonemergency medical transportation services

Table 26. Experience and Qualifications (26 of 43)

Nevada	
a. State/Program name.	Nevada/Nevada Medicaid
b. Start and end date.	Contract Origination Date: 4/1/1997 Current Contract: 1/1/2022 – 12/31/2025, with the possibility of two, one-year extensions.
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for physical health, BH, pharmacy, transportation, vision services, and serious emotional disturbance (SED)/serious mental illness (SMI) services, home- and community-based services (HCBS) and nonemergency services for certain services. Long-term services and supports (LTSS) are included for certain Members.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Individuals with Intellectual or Developmental Disabilities (IDD), Children's Health Insurance Program (CHIP), Child Health Assurance Program (CHAP), Expansion, Dual Eligible Individuals, and Temporary Assistance for Needy Families (TANF), including Children & Youth with Special Health Care Needs (CYSHCN).
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 2,753,542 Average Members per Month: 229,462
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ OmniClaim — payment integrity program services ▪ OptumInsight, Inc. — payment integrity program services ▪ Optum Mountain West — credentialing ▪ OptumRx, Inc. — pharmacy benefit management

Nevada	
	Non-Affiliates: ▪ Dispatch Health — credentialing ▪ EyeMed — optometry network, credentialing, claims ▪ Inovalon — targeted gaps in care solutions, credentialing, claims, network ▪ Intermountain Health Corp (IHC) — credentialing

Table 27. Experience and Qualifications (27 of 43)

New Jersey	
a. State/Program name.	New Jersey/New Jersey Medicaid
b. Start and end date.	Contract Origination Date: 1/1/1995 Current Contract: 7/1/2022 – 12/30/2023. This contract renews every six months.
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for physical health, BH for MLTSS Members and Individuals with Intellectual or Developmental Disabilities (IDD), dental, pharmacy, vision services and home- and community-based services (HCBS), Child Welfare Specialty Plan Services (case management for Members in DCPandP) and HIV/AIDS Specialty Plan Services, including Care Management and Open Access Pharmacy. Services also include Nursing Facility, Skilled Care Nursing Facility (SCNF), Home and Community, Assisted Living (Dual and Non-Dual) and individuals with Traumatic Brain Injuries. We cover all medical services as well as inpatient BH services for children/youth in Foster Care receiving title IV-E foster care payments or with title IV-E adoption.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Children's Health Insurance Program (CHIP), Dual Eligible Individuals, Expansion, Long-Term Care (LTC), Aged, Blind and Disabled (ABD), Individuals with Intellectual or Developmental Disabilities (IDD), and Temporary Assistance for Needy Families (TANF) populations, individuals receiving Supplemental Security Income (SSI) with or without Medicare, including Children with Children & Youth with Special Health Care Needs (CYSHCN), Foster Care (FC), Former Foster Youth (FFY) and Juvenile Justice System (JJS) populations.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 5,146,894 Average Members per Month: 428,908
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.

New Jersey	
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services

Table 28. Experience and Qualifications (28 of 43)

New York (Contract 1 of 2)	
a. State/Program name.	New York/New York Medicaid and HARP
b. Start and end date.	Contract Origination Date: 3/1/2014 Current Contract: 3/1/2019 – 2/29/2024
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for physical health, BH, dental, vision services, home- and community-based services (HCBS), children aged 0–18 and adults over age 21, HIV/AIDS services, long-term services and supports (LTSS), Aged, Blind and Disabled (ABD), and dual eligible Members. Retail pharmacy benefits were carved out to the State Fee-for-Services program effective April 1, 2023. The carve-out includes Members enrolled in Medicaid and HARP. Physician Administered Medications are covered by Managed Care Medicaid and HARP. NOTE: The Wellness4Me (HARP) plan covers adults aged 21 and older, identified as having SMI and/or serious substance use disorder as defined by the state. It covers HIV/AIDS services and Long-Term Care (LTC).

New York (Contract 1 of 2)	
	Members enrolled in Medicaid and HARP are assessed for LTSS, include 65 and older and individuals with physical and developmental disabilities and dual eligible beneficiaries. Foster Care children are included in the Medicaid population. The foster care children receive all the same services as the Medicaid population, but without limits. Specialty services are covered by the plan. Some specialty services require a PCP referral.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Aged, Blind and Disabled (ABD), Individuals with Intellectual or Developmental Disabilities (IDD), Expansion, Temporary Assistance for Needy Families (TANF), BH, Dual Eligible Individuals, Foster Care (FC), and Children & Youth with Special Health Care Needs (CYSHCN).
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 4,479,018 Average Members per Month: 373,252
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services

Table 29. Experience and Qualifications (29 of 43)

New York (Contract 2 of 2)	
a. State/Program name.	New York/Child Health Plus
b. Start and end date.	Contract Origination Date: 1/1/2008 Current Contract: 4/1/2019 – 9/30/2024
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for physical health, BH, dental, pharmacy, emergency transportation and vision services.
d. Covered population(s).	Children's Health Insurance Program (CHIP), Newborn, and only children aged 0–18 who are eligible for CHIP and meet eligibility requirements/income limits. Pregnant Members age 18 or younger may be eligible for CHIP and Foster Care (FC). Adults (age 18 and older) are not eligible for the CHIP plan. Children aged 0–18 and foster care children may be eligible to enroll in CHIP.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 254,147 Average Members per Month: 21,179
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services

Table 30. Experience and Qualifications (30 of 43)

North Carolina	
a. State/Program name.	North Carolina/Prepaid Health Plan Services (Medicaid)
b. Start and end date.	Contract Origination Date: 2/4/2019 Current Contract: 7/1/2021 – 12/1/2026
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for physical health, BH, pharmacy, transportation, vision and home- and community-based services (HCBS), skilled nursing facility services less than 90 days and long-term services and supports (LTSS), including personal care services (PCS) and private duty nursing (PDN), and community-based BH services are included. LTSS per North Carolina Department of Health and Human Services (DHHS) include Private Duty Nursing, Personal Care Services, Hospice, Home Health Services and Skilled Nursing Facilities (transfers to state after 90 days). Personal Care Services for eligible Members.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Dual eligible individuals, Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP), Aged, Blind and Disabled (ABD) and individuals receiving Supplemental Security Income (SSI) without Medicare, including Children & Youth with Special Health Care Needs (CYSHCN) population. NOTE: Children & Youth with Special Health Care Needs (CYSHCN) population is blended into the Temporary Assistance for Needy Families (TANF) population and possibly some in the Aged, Blind and Disabled (ABD) population. They do not receive special or different benefits from the other children within our Standard Plan Medicaid population.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 4,624,182 Average Members per Month: 385,349
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services

North Carolina	
	▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Modivcare Solutions, LLC — nonemergency medical transportation services

Table 31. Experience and Qualifications (31 of 43)

Ohio (Contract 1 of 2)	
a. State/Program name.	Ohio/Ohio Medicaid Provider Agreement for Managed Care Organization (Next Generation)
b. Start and end date.	Contract Origination Date: July 1, 2005 Current Contract: 7/1/2021 – 6/30/2024
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for physical health, BH, dental, transportation and vision services. Services for children in foster care, adoption assistance and juvenile justice cross over in the state of Ohio. We collaborate with foster parents, family members, child welfare professionals in the counties, and community partners who help children and youth in foster care.
d. Covered population(s).	Adults, Children (aged 0–18), Newborn, Aged, Blind and Disabled (ABD), Individuals with Intellectual or Developmental Disabilities (IDD), Children's Health Insurance Program (CHIP), Expansion and Temporary Assistance for Needy Families (TANF) populations, Partners for Kids (PFK) receiving Supplemental Security Income (SSI) without Medicaid and Medicare Advantage (SSI/ABD under 21 population), Foster Care (FC), Adoption Assistance (AA), Juvenile Justice System (JJS), Former Foster Youth (FFY), Children & Youth with Special Health Care Needs (CYSHCN), and Partners for Kids (PFK). NOTE: Ohio does not have a separate Children's Health Insurance Program (CHIP). The children's population is blended with Temporary Assistance for Needy Families (TANF) and Aged, Blind and Disabled (ABD)/ Supplemental Security Income (SSI). Premium Sharing [specific population of TANF kids and Aged, Blind and Disabled over age 21 that is delegated to an

Ohio (Contract 1 of 2)	
	accountable care organization (ACO)] is a fully capitated Managed Care model.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 4,210,304 Average Members per Month: 350,858
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ DentaQuest — dental health services eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Outcomes MTM Incorporated — utilization management ▪ Partners for Kids — care management ▪ Provide-a-Ride — nonemergency medical transportation services

Table 32. Experience and Qualifications (32 of 43)

Ohio (Contract 2 of 2)	
a. State/Program name.	Ohio/MyCare Ohio (Medicare-Medicaid Plan – MMP)
b. Start and end date.	3-way: Traditional Contract Origination Date: 5/1/2014 Current Contract: 1/1/2022 – 12/31/2023 NOTE: We are in the process of signing an extension through 12/31/24. 2-way: Lite Contract Origination Date: 5/1/2014 Current Contract: 7/1/2023 – 12/31/2023

Ohio (Contract 2 of 2)	
	NOTE: The 3-way agreement is between Centers for Medicare and Medicaid Services (CMS), the state, and the plan. The 2-way agreement is between the state and the plan and covers items specific to state requirements that are beyond what is in the 3-way agreement.
c. Services covered under the contract.	All covered services in the standard Medicare and Medicaid benefit package for physical health, BH, dental, pharmacy, transportation, home- and community-based services (HCBS), and vision services and long-term services and supports (LTSS). NOTE: If a Member is considered opted out, only the Medicaid portion of the benefit applies through the plan. The Medicare portion (including the Part D benefit) would be covered outside of the MMP product. NOTE: We serve Members in three of the seven ICDS regions. Three population subsets are within the dual eligible group: nursing facility, community-well and LTSS waiver.
d. Covered population(s).	Covers dual eligible populations who are aged 18 or older, older adults (65 and older), and individuals with physical disabilities and Dual Eligible beneficiaries.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 348,109 Average Members per Month: 29,009
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ DentaQuest — dental health services

Ohio (Contract 2 of 2)	
	▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Provide-A-Ride — nonemergency medical transportation services

Table 33. Experience and Qualifications (33 of 43)

Pennsylvania (Contract 1 of 2)	
a. State/Program name.	Pennsylvania/HealthChoices
b. Start and end date.	Contract Origination Date: 7/1/1989 Current Contract: 9/1/2022 – 9/30/2027, with option for one, three-year period extension
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for physical health, dental, pharmacy, transportation, home- and community-based services (HCBS), vision services, Child Welfare Specialty Plan Services, Serious Mental Illness (SMI) Specialty Plan Services, and HIV/AIDS Specialty Plan Services. Through this contract, we participate and facilitate a number of processes geared toward managing Members in the foster care and juvenile probation system.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Dual eligible individuals, Aged, Blind and Disabled (ABD), Individuals with Intellectual or Developmental Disabilities (IDD), Expansion and Temporary Assistance for Needy Families (TANF), including Adoption Assistance (AA), Children & Youth with Special Health Care Needs (CYSHCN), Foster Care (FC), Former Foster Youth (FFY) and Juvenile Justice System (JJS) populations.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 1,547,013 Average Members per Month: 128,918
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management,

Pennsylvania (Contract 1 of 2)	
	payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ Optum Transplant — Transplant Network Access and Case Management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Progeny — NICU case management and utilization review

Table 34. Experience and Qualifications (34 of 43)

Pennsylvania (Contract 2 of 2)	
a. State/Program name.	Pennsylvania/Pennsylvania CHIP
b. Start and end date.	Contract Origination Date: 12/1/1999 Current Contract: 3/1/2020 – 12/31/2023
c. Services covered under the contract.	All covered services in the standard Children's Health Insurance Program (CHIP) benefit package for BH, physical health, dental, pharmacy, transportation, and vision services.
d. Covered population(s).	Children's Health Insurance Program (CHIP), Newborn
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 255,769 Average Members per Month: 21,314
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services

Pennsylvania (Contract 2 of 2)	
	▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services

Table 35. Experience and Qualifications (35 of 43)

Rhode Island	
a. State/Program name.	Rhode Island/Rhode Island Medicaid
b. Start and end date.	Contract Origination Date: 8/1/1994 Current Contract: 3/1/2017 – 6/30/2024, with one-year option to extend.
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for BH, physical health, pharmacy, emergency transportation, vision, dental, home- and community-based services (HCBS), HCBS for at-risk populations and nonemergency medical transportation.
d. Covered population(s).	Children (aged 0-18), Newborn Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP), Pregnant, Aged, Blind and Disabled (ABD), and Individuals with Intellectual or Developmental Disabilities (IDD) populations, and Dual Eligible Individuals' populations. It includes adults with disabilities (under MCAR section 0374) and eligible adults aged 19 to 64 without dependent children (under MCAR section 1311). In addition to Medicaid Members in Rhode Island, Medicaid is available to expansion populations via the Affordable Care Act. It is for individuals living in Rhode Island who are between the ages of 19 and 64 and who are not eligible for other Medicaid programs or Medicare Part A or B.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 1,211,304 Average Members per Month: 100,942
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.

Rhode Island	
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Rite Smiles — dental health services

Table 36. Experience and Qualifications (36 of 43)

Tennessee	
a. State/Program name.	Tennessee/TennCare
b. Start and end date.	Contract Origination Date: 1/1/1994 Current Contract: 1/1/2014 – 12/31/2023
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for BH, physical health, transportation, Individuals with Intellectual or Developmental Disabilities (IDD), long-term services and supports (LTSS) and vision service; and home- and community-based services (HCBS), plus benefits that go above the standard Medicaid benefit package known as CHOICES and ECF CHOICES. LTSS in Tennessee is made up of the CHOICES and the Employment and Community First CHOICES programs. Tennessee's CHOICES program includes nursing facility services and HCBS for adults age 21 and older with a physical disability and seniors (aged 65 and older). Through the ECF CHOICES program, UnitedHealthcare provides coordinated services to help people with IDD gain as much independence as possible. People are supported to live with their family or in the community, not in an institution. Residential services are available for adults with IDD who do not live with family but need supports where they live. Employment and Community First CHOICES is for people of all ages who have an intellectual or developmental disability (IDD). This includes people who have significant disabilities. Services help people with IDD gain as much independence as possible.

Tennessee	
	People are supported to live with their family or in the community, not in an institution. Residential services are available for adults with IDD who do not live with family but need supports where they live.
d. Covered population(s).	Adults, Children (aged 0–18), Newborn, Pregnant, Individuals with Intellectual or Developmental Disabilities (IDD), Dual Eligible Individuals, Foster Care (FC), Children's Health Insurance Program (CHIP), Long-Term Care (LTC), Aged, Blind and Disabled (ABD), Temporary Assistance for Needy Families (TANF), Employment and Community First (ECF) CHOICES.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 6,440,570 Average Members per Month: 536,714
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ Eventa, LLC — delegated utilization management services ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Launchpoint d.b.a. Discovery Health Partners — payment integrity Support ▪ Performant — payment integrity support ▪ Recovery Data Connect — payment integrity support ▪ SCIO/EXL Health Services — clinical audits for Medicaid claims ▪ Tennessee Carriers, Inc. — nonemergency medical transportation services

Table 37. Experience and Qualifications (37 of 43)

Texas (Contract 1 of 4)	
a. State/Program name.	Texas/HHSC Uniform Managed Care Contract (UMCC) – Texas STAR (Medicaid)
b. Start and end date.	Contract Origination Date: 9/1/2006 Current Contract: 9/1/2023 – 8/31/2024
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for BH, physical health, dental, pharmacy, transportation, and vision service.
d. Covered population(s).	Adults, Children (aged 0–18), Newborn, Dual Eligible Individuals, Temporary Assistance for Needy Families (TANF) populations, including low-income children, pregnant Members and families who are covered under Medicaid in Texas.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 3,064,669 Average Members per Month: 255,389
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Modivcare Solutions, LLC — nonemergency medical transportation services ▪ Texas Association of Health Plans (TAHP) — credentialing and recredentialing

Table 38. Experience and Qualifications (38 of 43)

Texas (Contract 2 of 4)	
a. State/Program name.	Texas/HHSC Uniform Managed Care Contract (UMCC) – Texas CHIP
b. Start and end date.	Contract Origination Date: 5/1/2007 Current Contract: 9/1/2023 – 8/31/2024
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for BH, physical health, dental, pharmacy, transportation and vision service.
d. Covered population(s).	Children's Health Insurance Program (CHIP)
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 36,685 Average Members per Month: 3,057
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Modivcare Solutions, LLC — nonemergency medical transportation services ▪ Texas Association of Health Plans (TAHP) — credentialing and recredentialing

Table 39. Experience and Qualifications (39 of 43)

Texas (Contract 3 of 4)	
a. State/Program name.	Texas/HHSC Uniform Managed Care Contract (UMCC) Contract Texas STAR+PLUS
b. Start and end date.	Contract Origination Date: 1/1/1998 Current Contract: 9/1/2023 – 8/31/2024
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for BH, physical health, dental, pharmacy, transportation, home- and community-based services (HCBS), and vision service; includes long-term services and supports (LTSS). Texas D-SNP does have Members that include the TX STAR+PLUS product (the LTSS product for TX Medicaid).
d. Covered population(s).	Adult, Children (aged 0–18), Newborn, Aged, Blind and Disabled (ABD), Long-Term Care (LTC), and Individuals with Intellectual or Developmental Disabilities (IDD) populations.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 1,826,758 Average Members per Month: 152,230
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Modivcare Solutions, LLC — nonemergency medical transportation services ▪ Texas Association of Health Plans (TAHP) — credentialing and recredentialing

Table 40. Experience and Qualifications (40 of 43)

Texas (Contract 4 of 4)	
a. State/Program name.	Texas/HHSC – Texas STAR Kids
b. Start and end date.	Contract Origination Date: 11/1/2016 Current Contract: 9/1/2023 – 8/31/2024
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for BH, physical health, dental, pharmacy, transportation, and vision service; includes long-term services and supports (LTSS).
d. Covered population(s).	Children aged 20 or younger who are covered by Medicaid; have a qualifying disability (i.e., Individuals with Intellectual or Developmental Disabilities (IDD), Blind and Disabled); meet at least one other coverage criteria — such as but not limited to — SSI, Medicaid, and Medicare, receive services through a waiver program, live in an ICF or nursing facility. Texas STAR Kids include Members with physical disabilities, individuals with intellectual and developmental disabilities, and dual eligible beneficiaries.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 346,300 Average Members per Month: 28,858
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Modivcare Solutions, LLC — nonemergency medical transportation services

Texas (Contract 4 of 4)	
	▪ Texas Association of Health Plans (TAHP) — credentialing and recredentialing

Table 41. Experience and Qualifications (41 of 43)

Virginia	
a. State/Program name.	Virginia/Cardinal Care Managed Care
b. Start and end date.	Contract Origination Date: 10/1/2023 Current Contract: 10/1/2023 – 6/30/2024 NOTE: The next contract is in the procurement process for effective date 7/1/24. Legacy Contracts: Cardinal Care joined Medallion 4.0 and Commonwealth Coordinated Care Plus contracts on 10/1/2023: ▪ Medallion 4.0: Contract Origination Date: 8/1/2018 ▪ Commonwealth Coordinated Care Plus: Contract Origination Date: 8/1/2017
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for BH, physical health, pharmacy, transportation, long-term services and supports (LTSS), home- and community-based services (HCBS), vision services; includes HCBS 1915(c) waiver benefits.
d. Covered population(s).	Adults, Pregnant, Aged, Blind and Disabled (ABD), Complex Expansion, Individuals with Intellectual or Developmental Disabilities (IDD), Children (aged 0–18), Newborn, Dual Eligible Individuals, Children's Health Insurance Program (CHIP), Long-Term Care (LTC), and Temporary Assistance for Needy Families (TANF), including Adoption Assistance (AA), Children & Youth with Special Health Care Needs (CYSHCN), Foster Care (FC), Former Foster Youth (FFY) and Juvenile Justice System (JJS) populations. This program covers Medicaid-eligible adults aged 65 or older; adults with disabilities; nursing facility residents, and those receiving LTSS. NOTE: CYSHCN defined as children and youth with special health care needs up to age 21 who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. These include, but are not limited to, the children in foster care and adoption assistance, youth who have aged out of the foster care system, children identified as Early Intervention (EI)

Virginia	
	participants, Members identified as experiencing childhood obesity and others as identified through the Contractor's assessment or by the Department.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 2,287,984 Average Members per Month: 190,665
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services ▪ United HealthCare Services, Inc. — administrative services Non-Affiliates ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services ▪ Modivcare Solutions, LLC — nonemergency medical transportation services

Table 42. Experience and Qualifications (42 of 43)

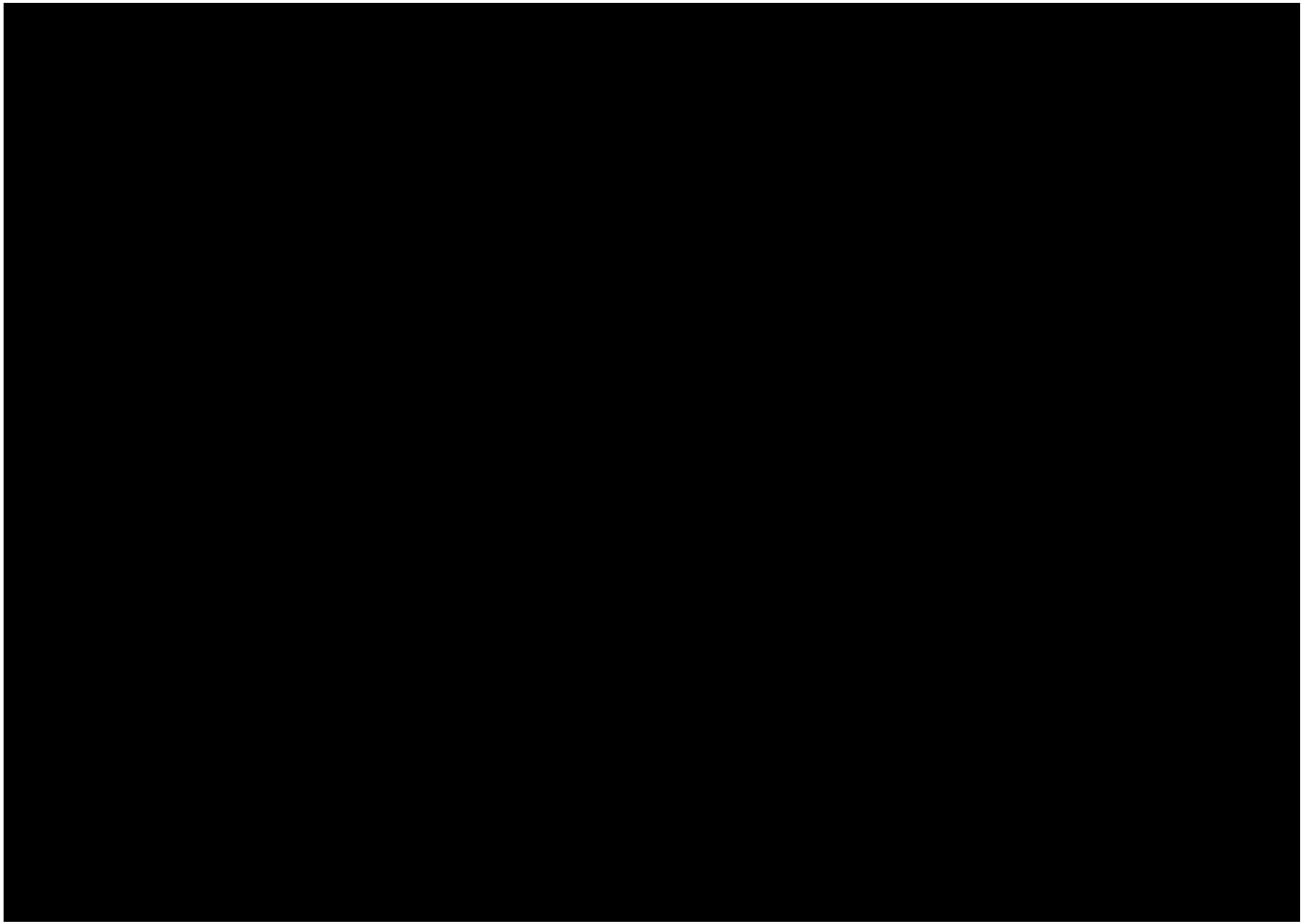
Washington	
a. State/Program name.	Washington/Washington Apple Health Integrated Managed Care
b. Start and end date.	Contract Origination Date: 7/1/2012 Current Contract: 1/1/2020 – 12/31/2023
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for BH, physical health, and pharmacy services.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Dual Eligible Individuals, Aged, Blind and Disabled (ABD), Individuals with Intellectual or Developmental Disabilities (IDD), Children's Health Insurance Program (CHIP), BH, Expansion, Temporary Assistance for Needy Families (TANF) and individuals receiving Supplemental Security Income (SSI) without Medicare, including Children & Youth with Special Health Care Needs (CYSHCN) populations.
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 3,263,336 Average Members per Month: 271,945

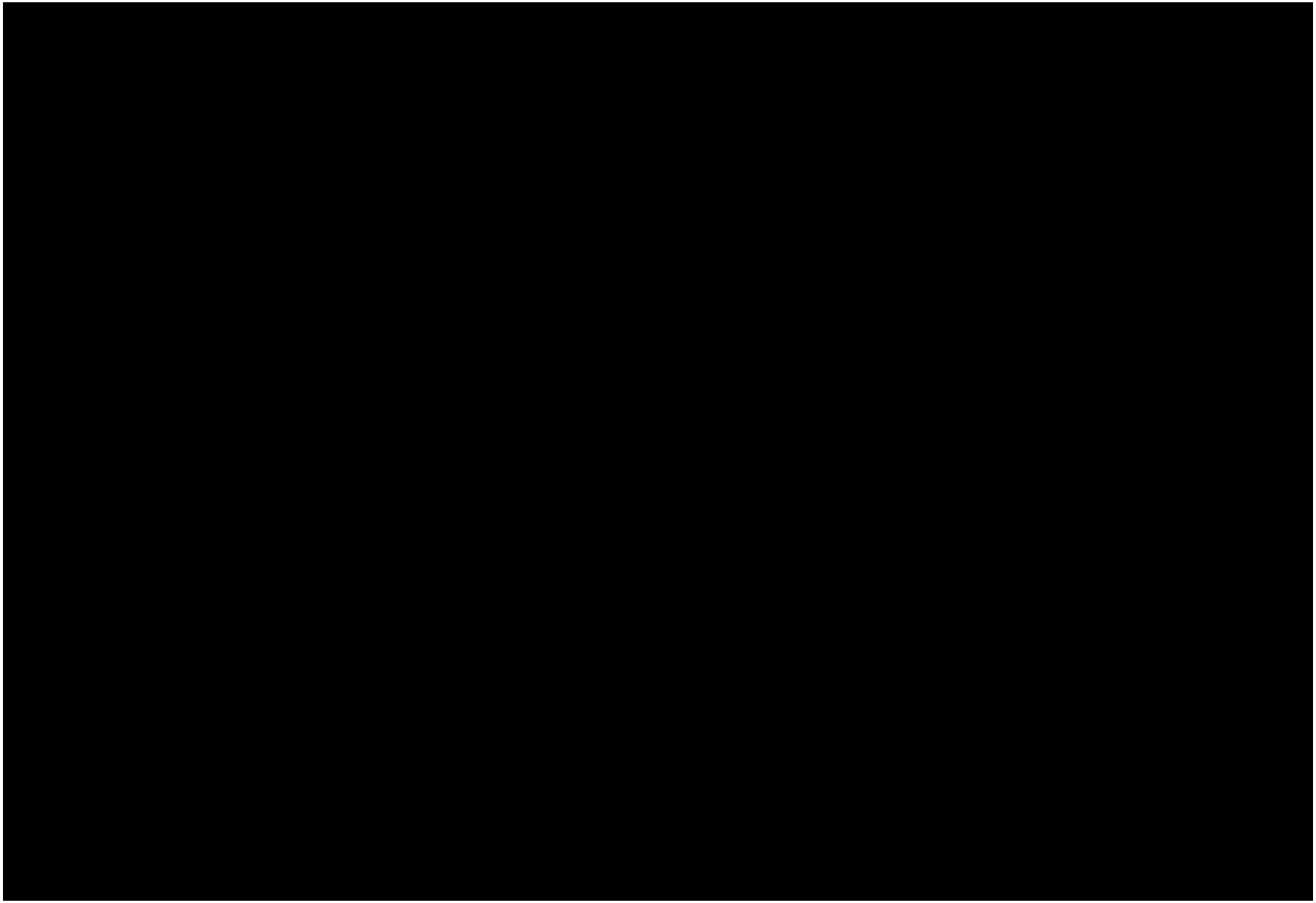
Washington	
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ March® Vision Care Group, Incorporated — vision care services ▪ Optum Care Network — UM, CM, Provider claims, calls, credentialing ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ OptumInsight, Inc. — payment integrity program services ▪ OptumRx, Inc. — pharmacy benefit management ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services Non-Affiliates: ▪ eviCore healthcare MSI, LLC d.b.a. eviCore healthcare — utilization management services/prior authorization for radiology and cardiology covered services

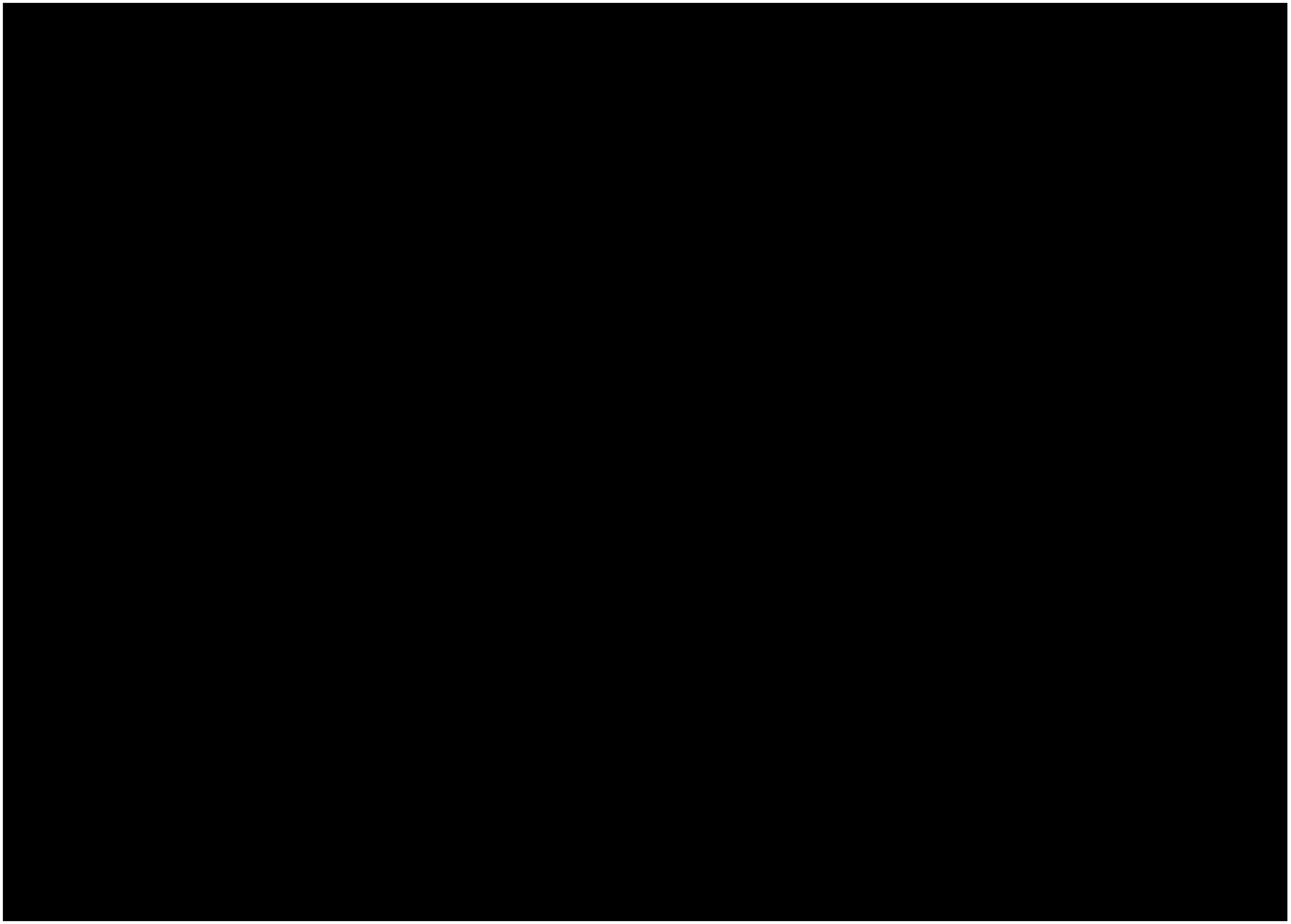
Table 43. Experience and Qualifications (43 of 43)

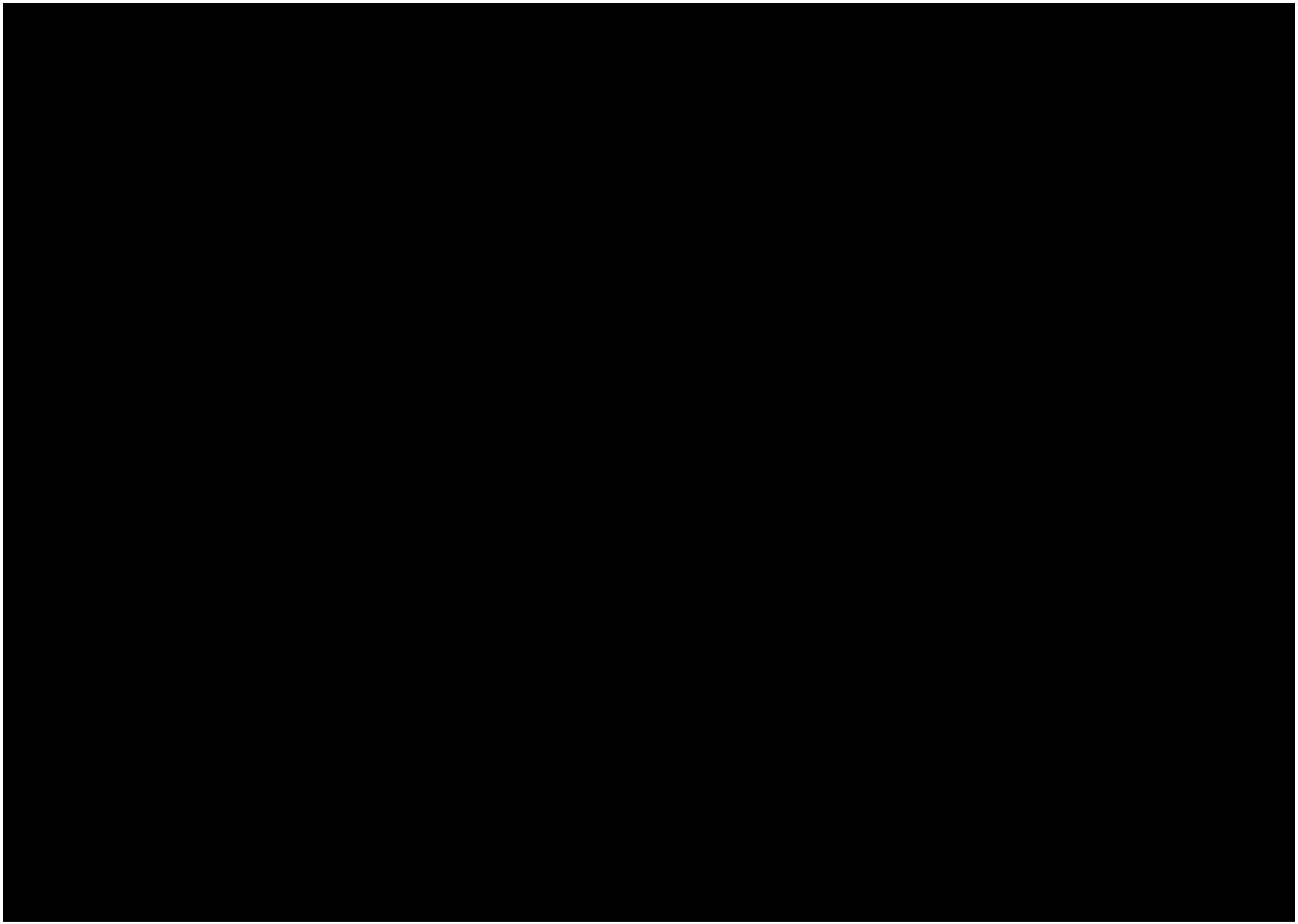
Wisconsin	
a. State/Program name.	Wisconsin/BadgerCare Plus and Medicaid SSI
b. Start and end date.	Contract Origination Date: 1/1/2005 Current Contract: 1/1/2022 – 12/31/2023, with annual renewal options
c. Services covered under the contract.	All covered services in the standard Medicaid benefit package for BH, physical health, home- and community-based services (HCBS), dental services in certain regions and transportation services. HIV/AIDS is a covered service, and the plan participates in pass-through payments to the selected Provider of services. NOTE: Foster Kids are carved out of our eligible population, and there is a separate carve-out program for Children's Long-Term Support (HCBS). There is a separate Katie Beckett Medicaid program for children under age 19 with complex medical and long-term disabilities, and mental health needs and wanting HCBS versus institutional care.
d. Covered population(s).	Adults, Pregnant, Children (aged 0–18), Newborn, Dual Eligible Individuals, Children's Health Insurance Program (CHIP), Aged,

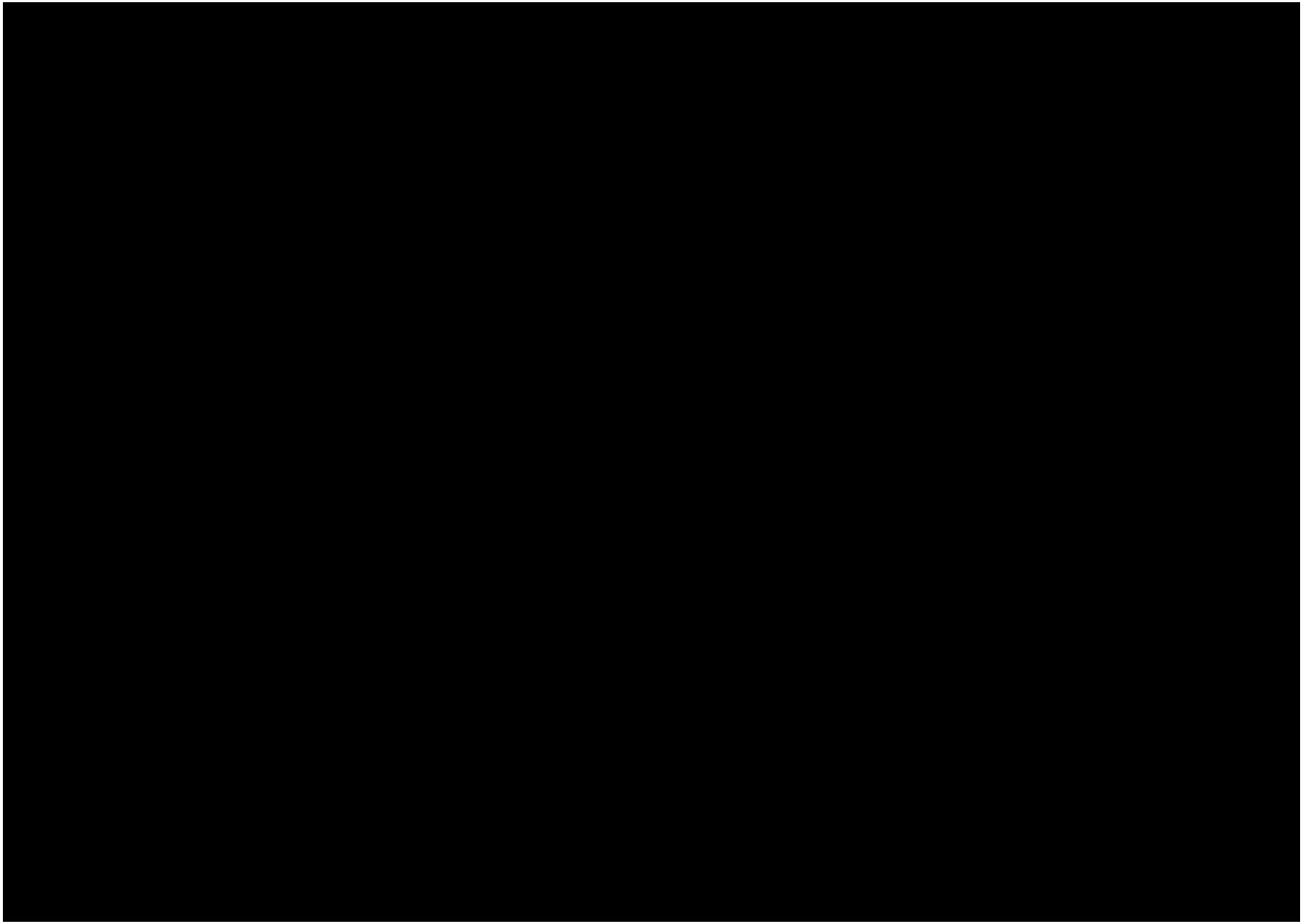
Wisconsin	
	Blind and Disabled (ABD), Childless Adults and Temporary Assistance for Needy Families (TANF) (parents and caretakers, children covered up to age 20) populations, including individuals receiving Supplemental Security Income (SSI) with or without Medicare, and Family Health Plus (FHP). NOTE: This contract does not cover Individuals with Intellectual or Developmental Disabilities (IDD) or Long-Term Care (LTC).
e. Average number of total member months.	Membership from October 2022 – September 2023: Total Member Months: 3,167,421 Average Members per Month: 263,952
f. Instances of non-compliance.	Per 4.3.H.4. of the RFP requirements, we have included instances of non-compliance as **Exhibit 1-1**.
g. Instances of breach(es) of unsecured PHI.	Per 4.3.H.4. of the RFP requirements, we have included instances of breach(es) of unsecured PHI as **Exhibit 1-2**.
h. Subcontractors performing delegated functions and functions performed.	Affiliates: ▪ Dental Benefit Providers, Inc. — dental health services ▪ March® Vision Care Group, Incorporated — vision care services ▪ OptumHealth Care Solutions, LLC — care management, NurseLine, Centers of Excellence, utilization management, payment integrity services, and network management for chiropractic, occupational, physical and speech therapy services ▪ United Behavioral Health, Inc. (operating under the brand name Optum) — BH services

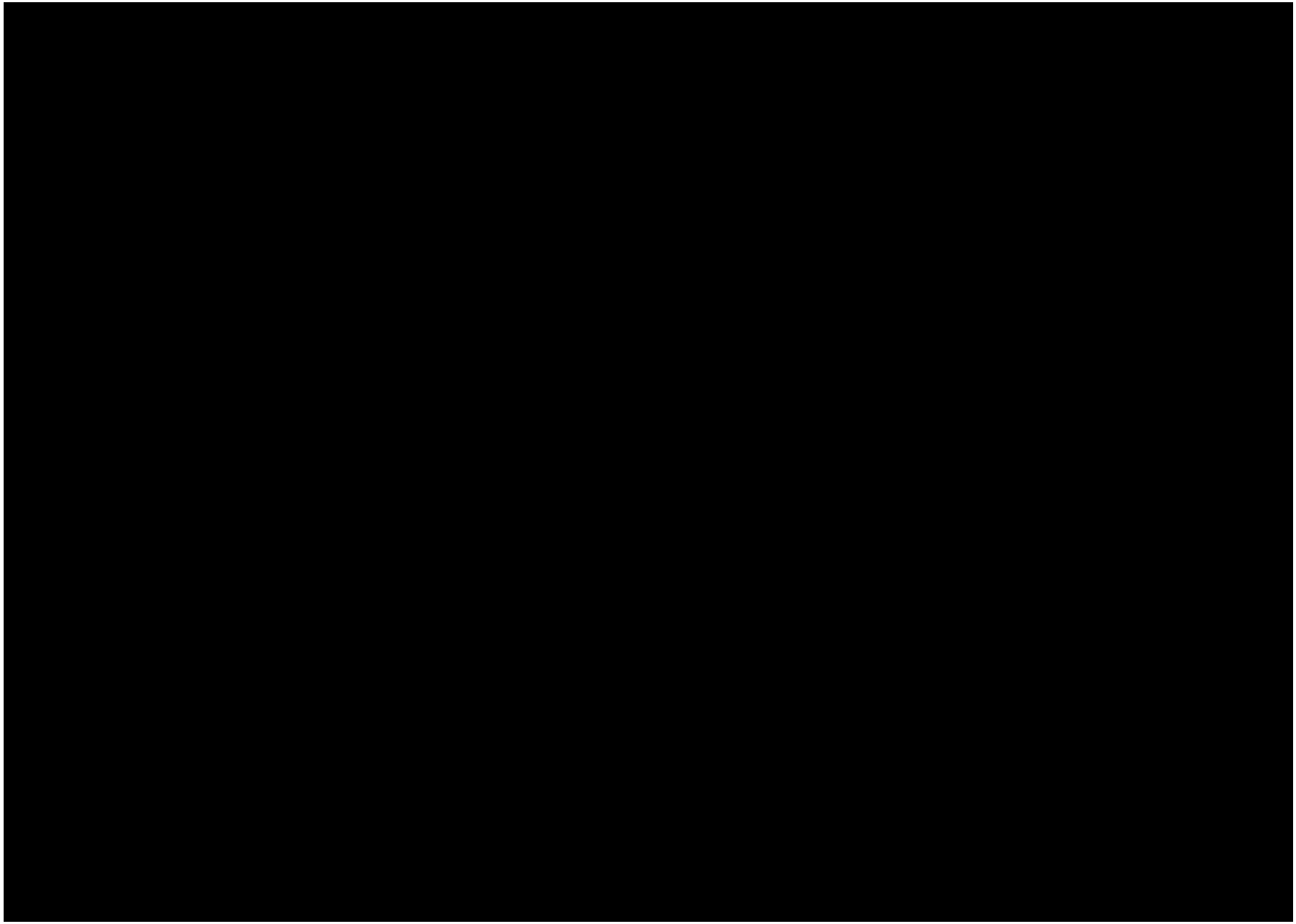


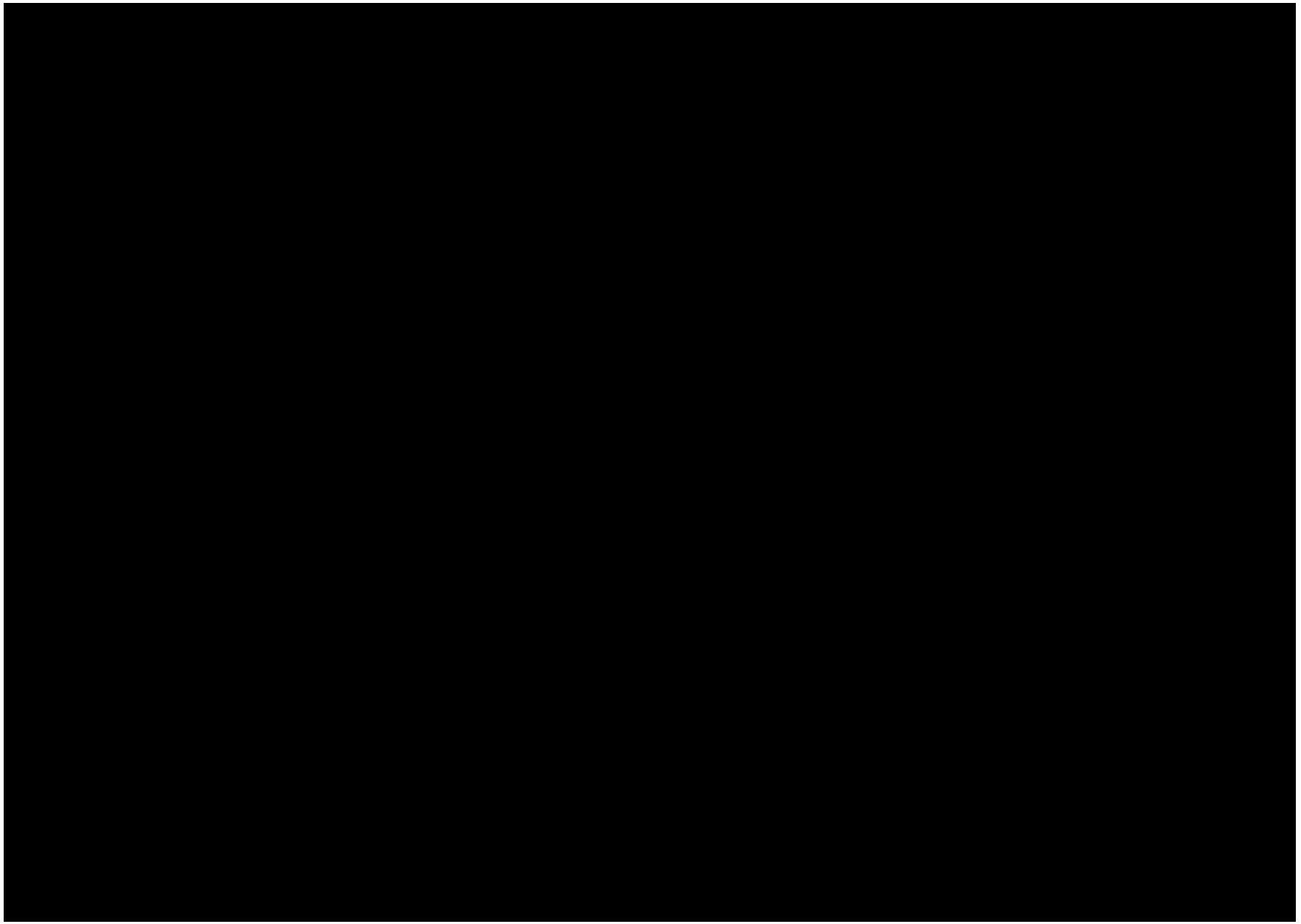


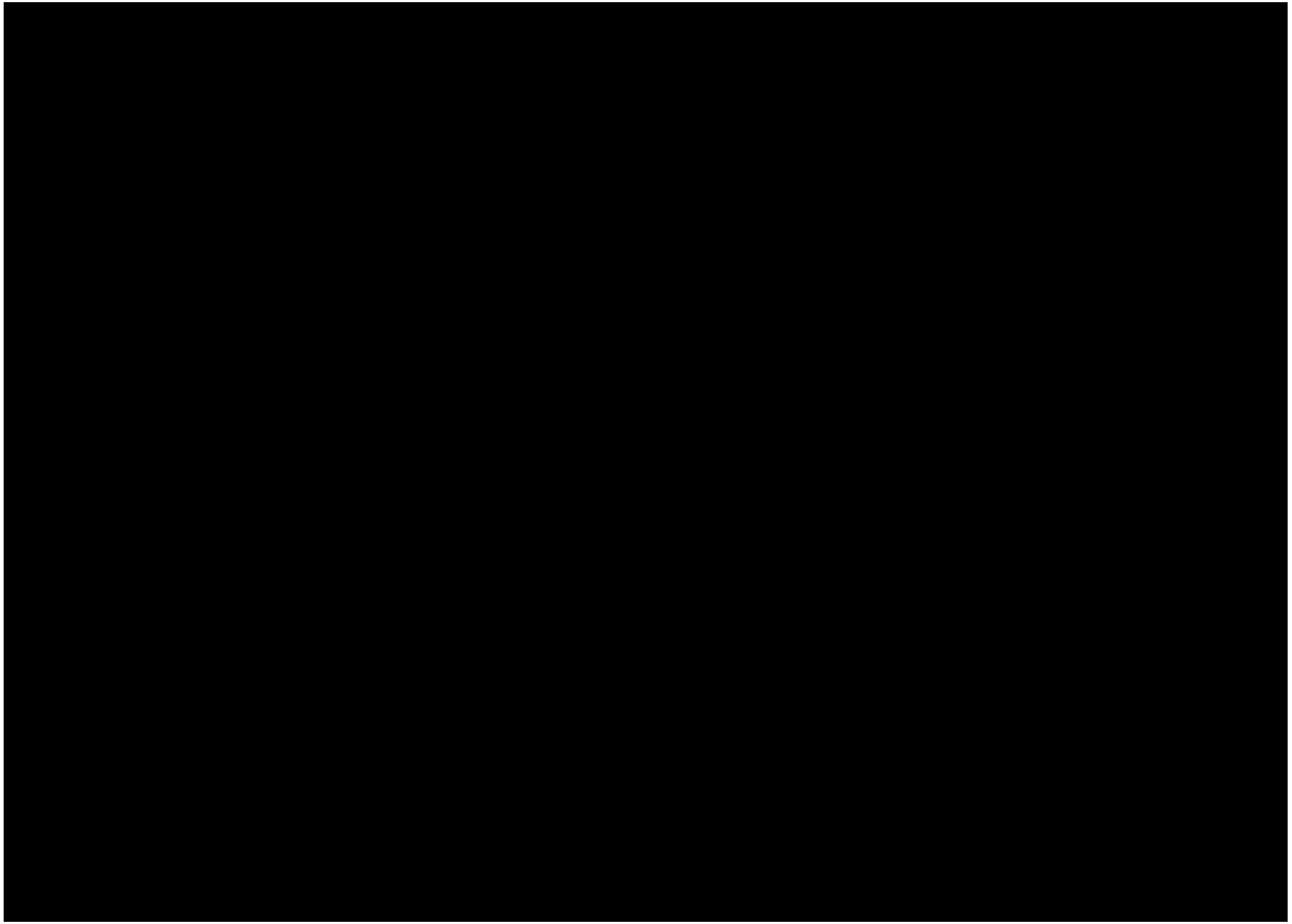


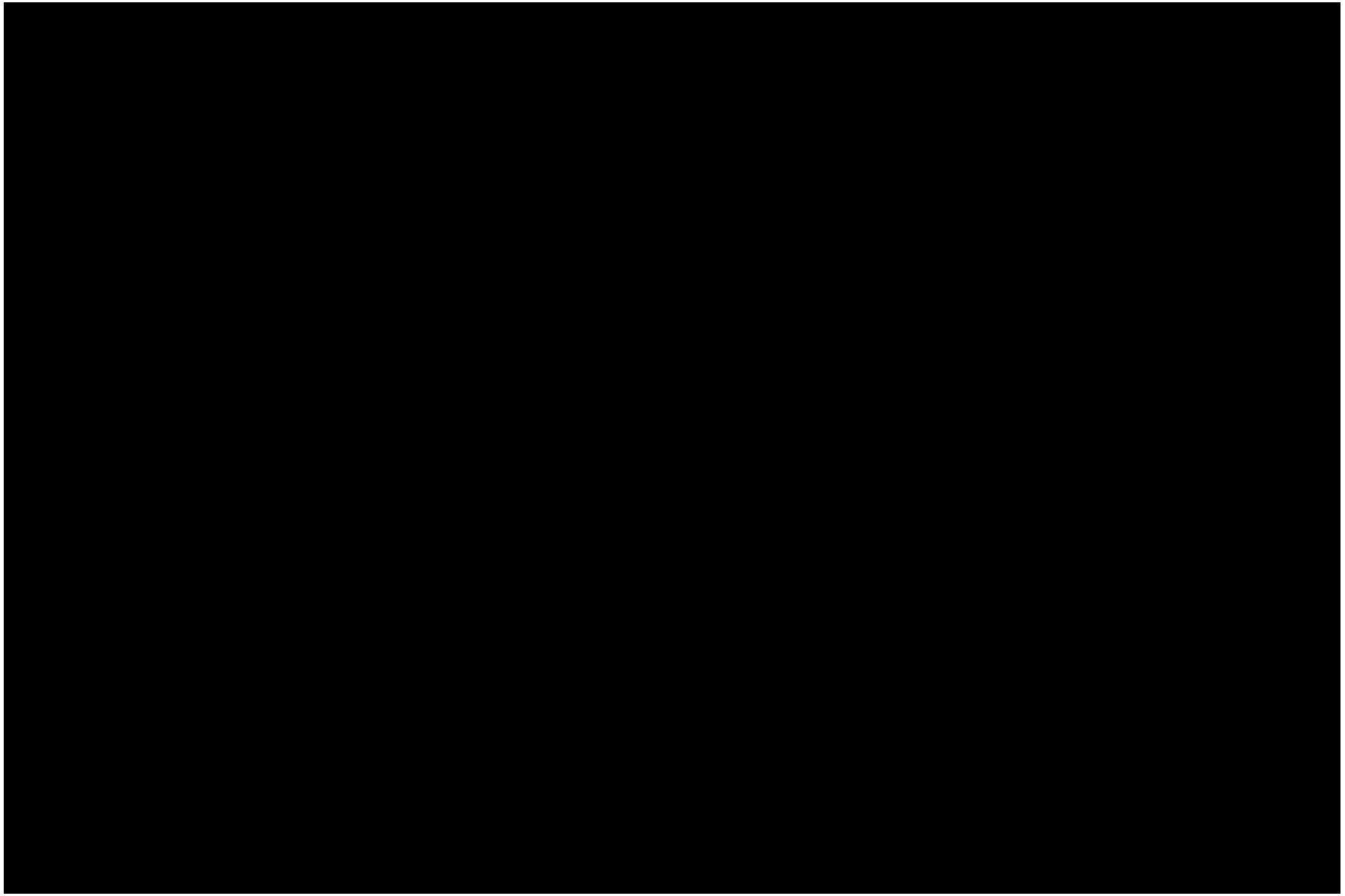


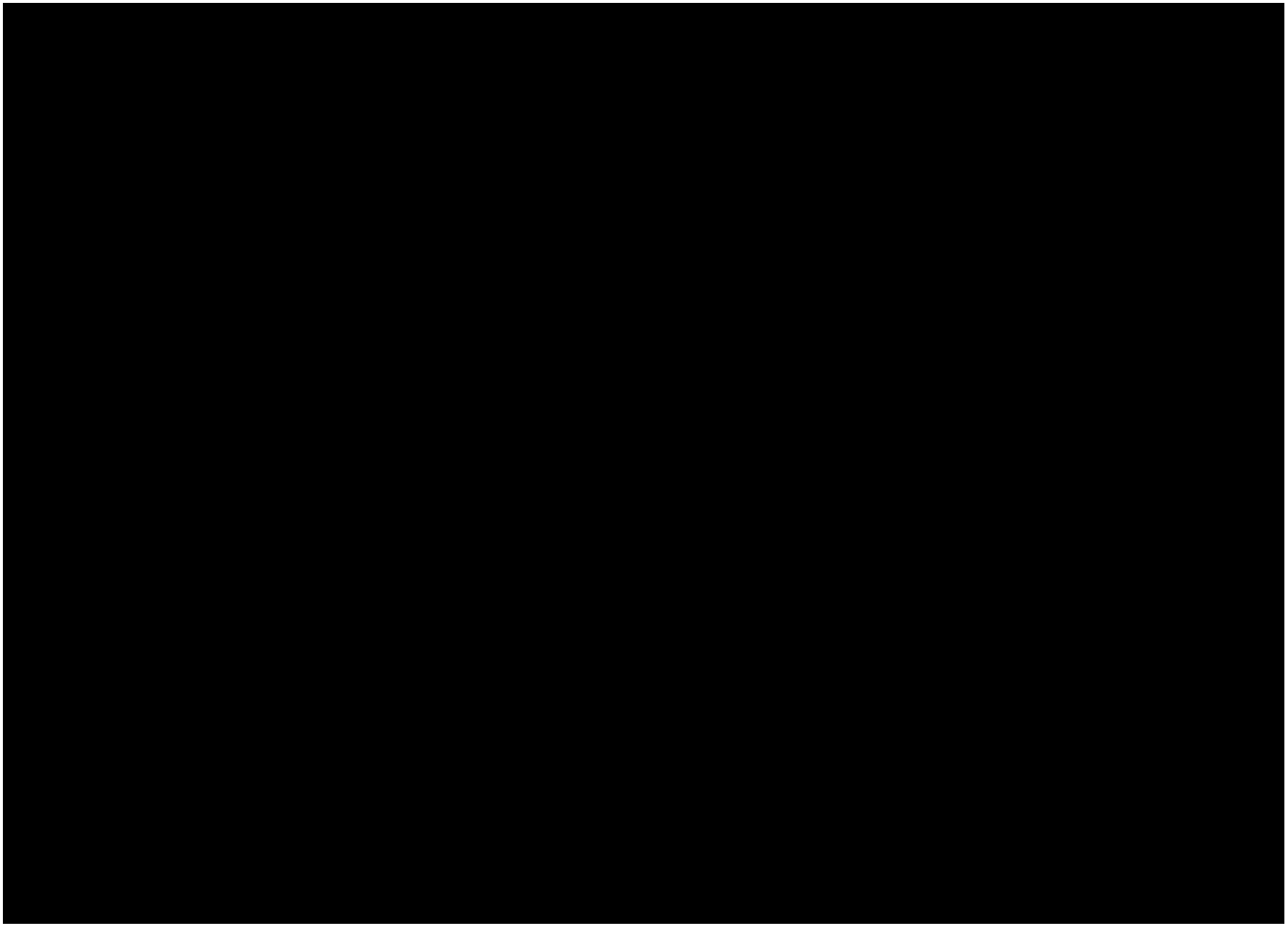


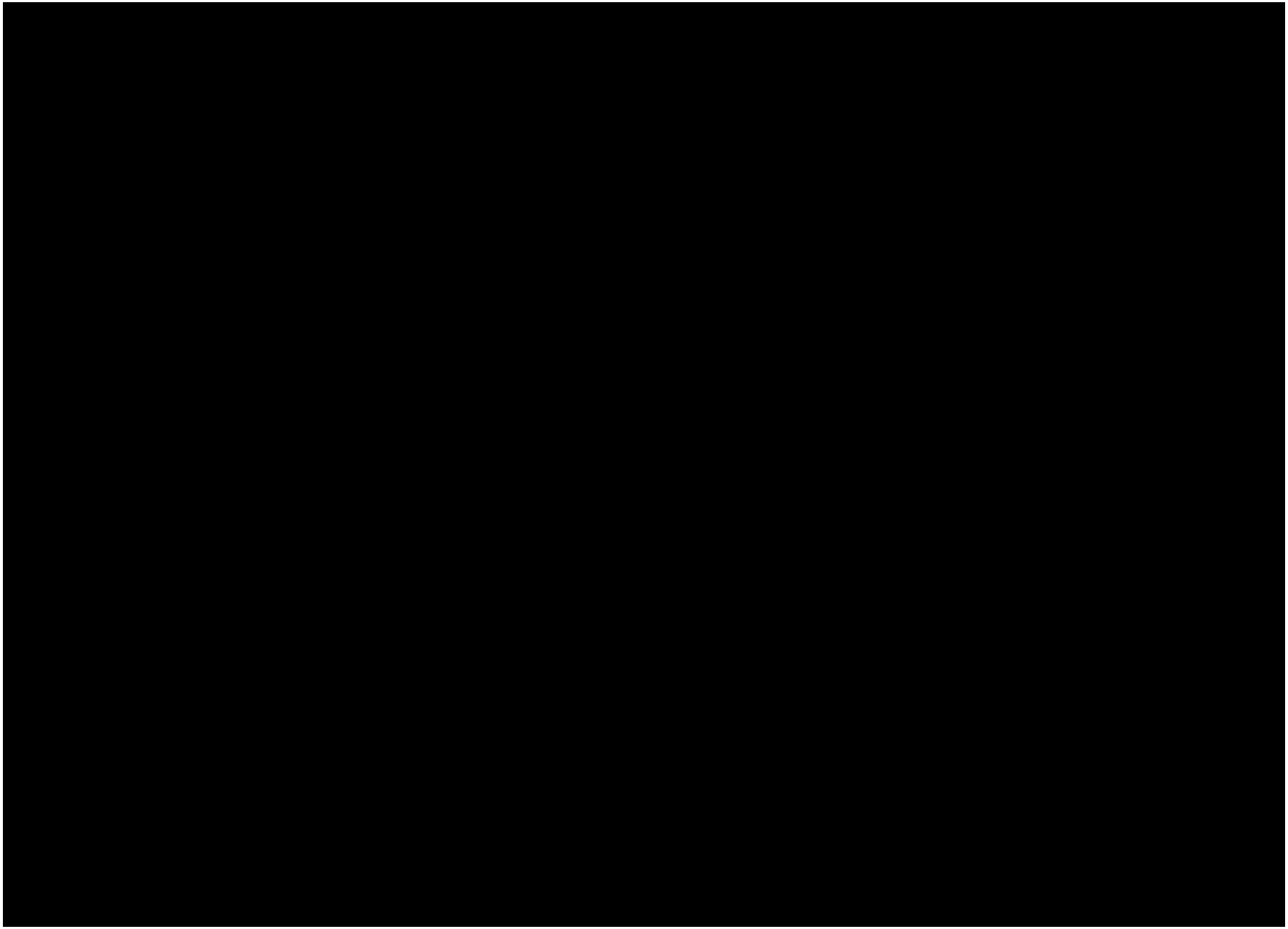


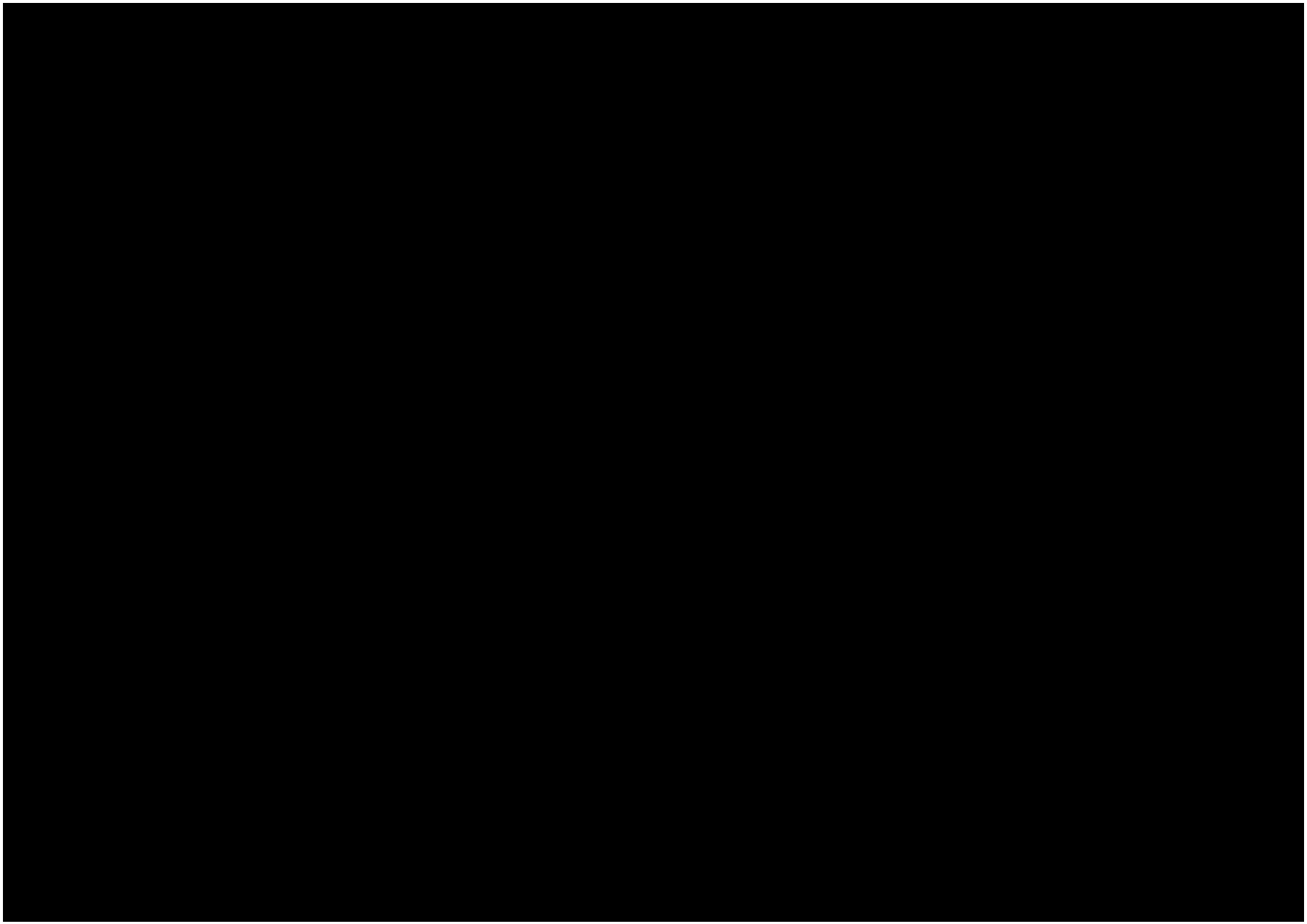


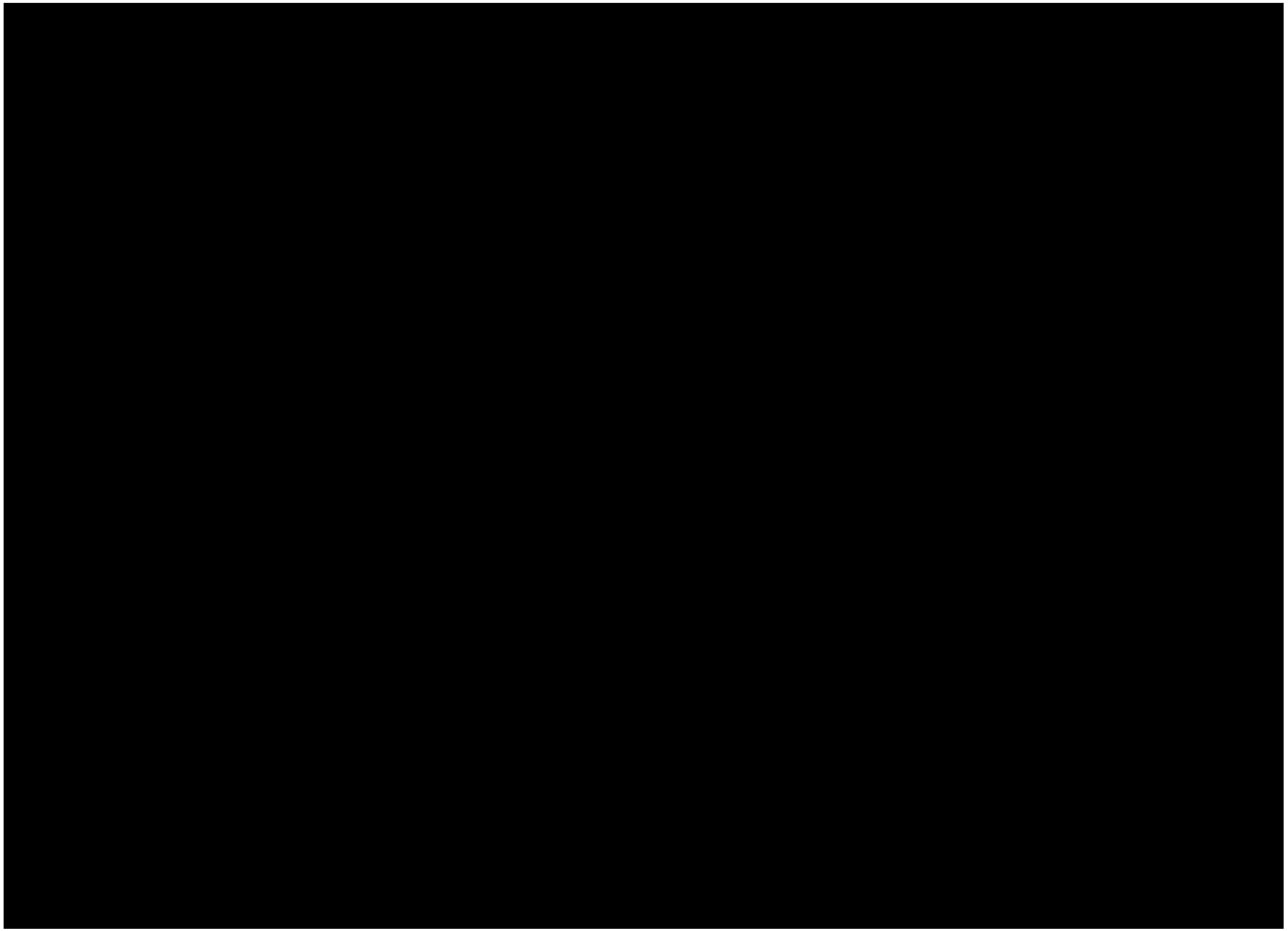


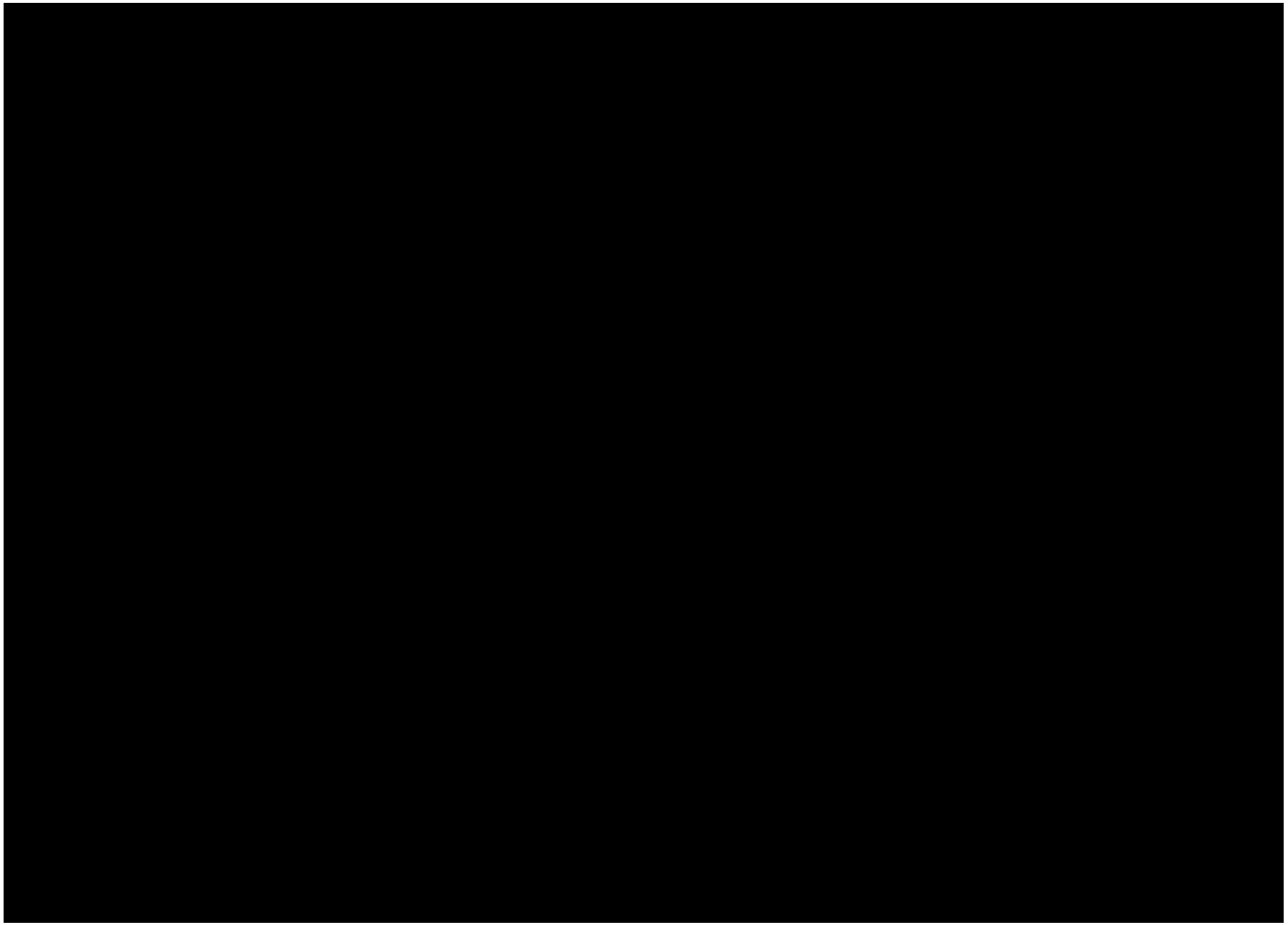


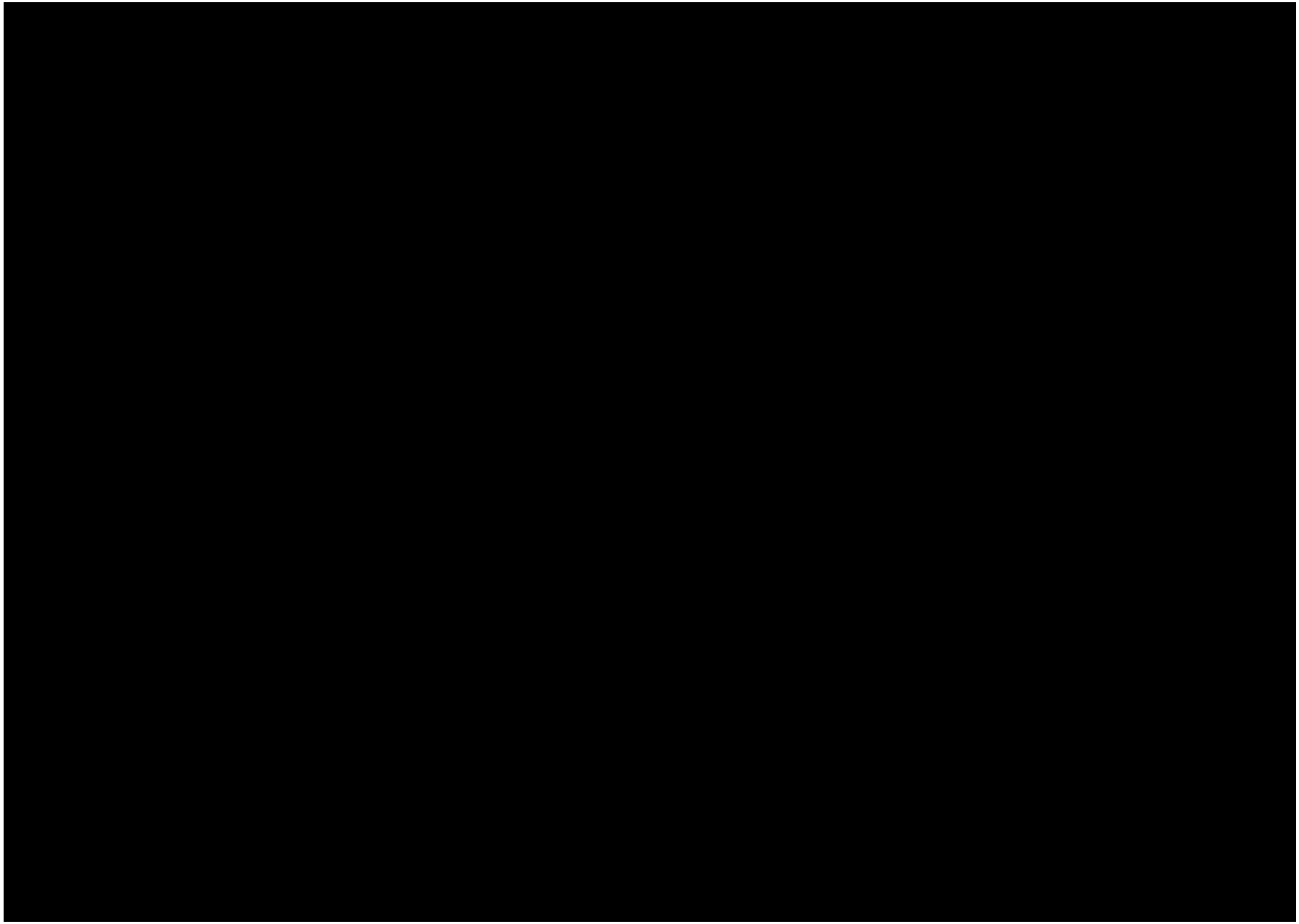


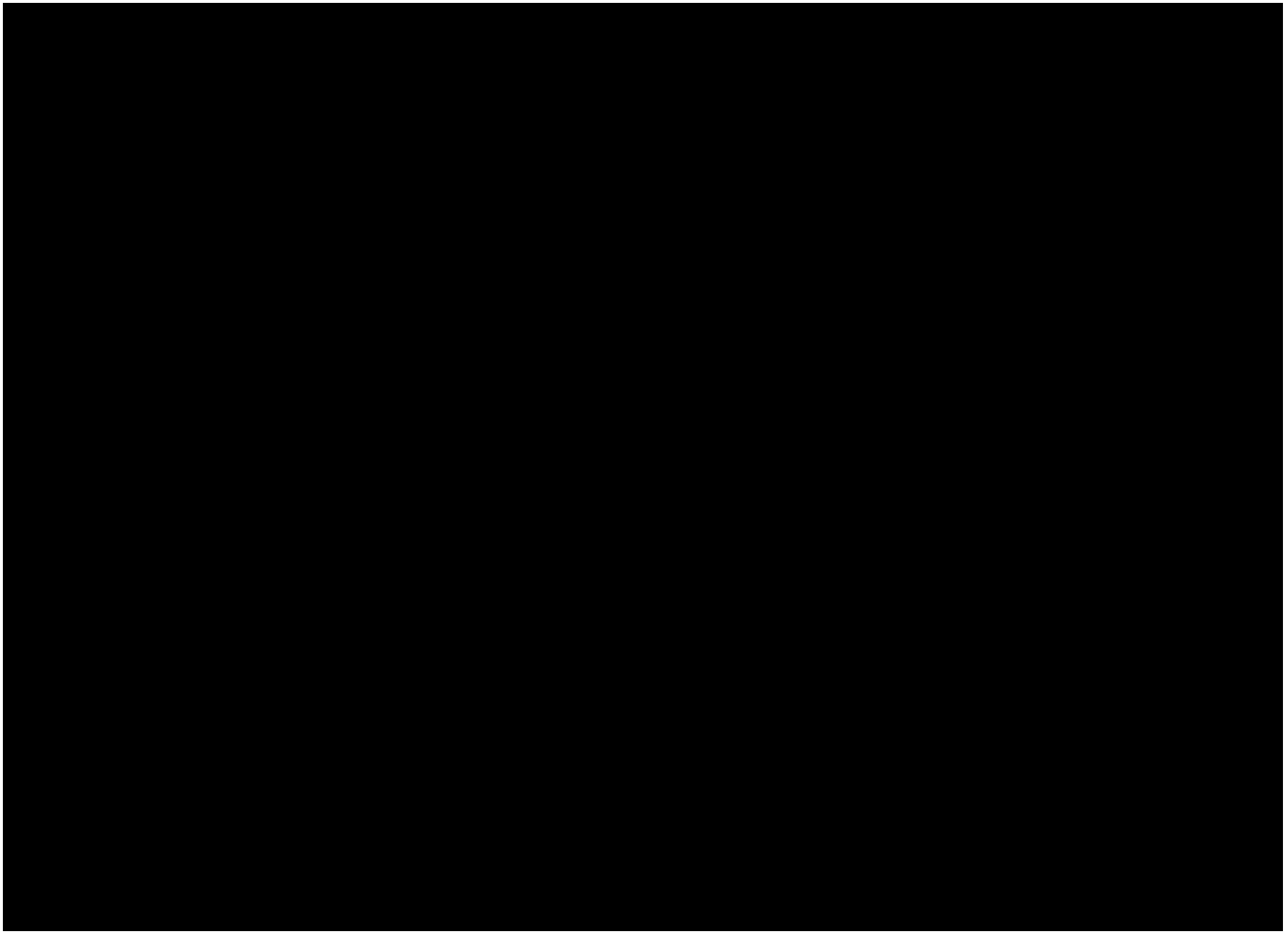


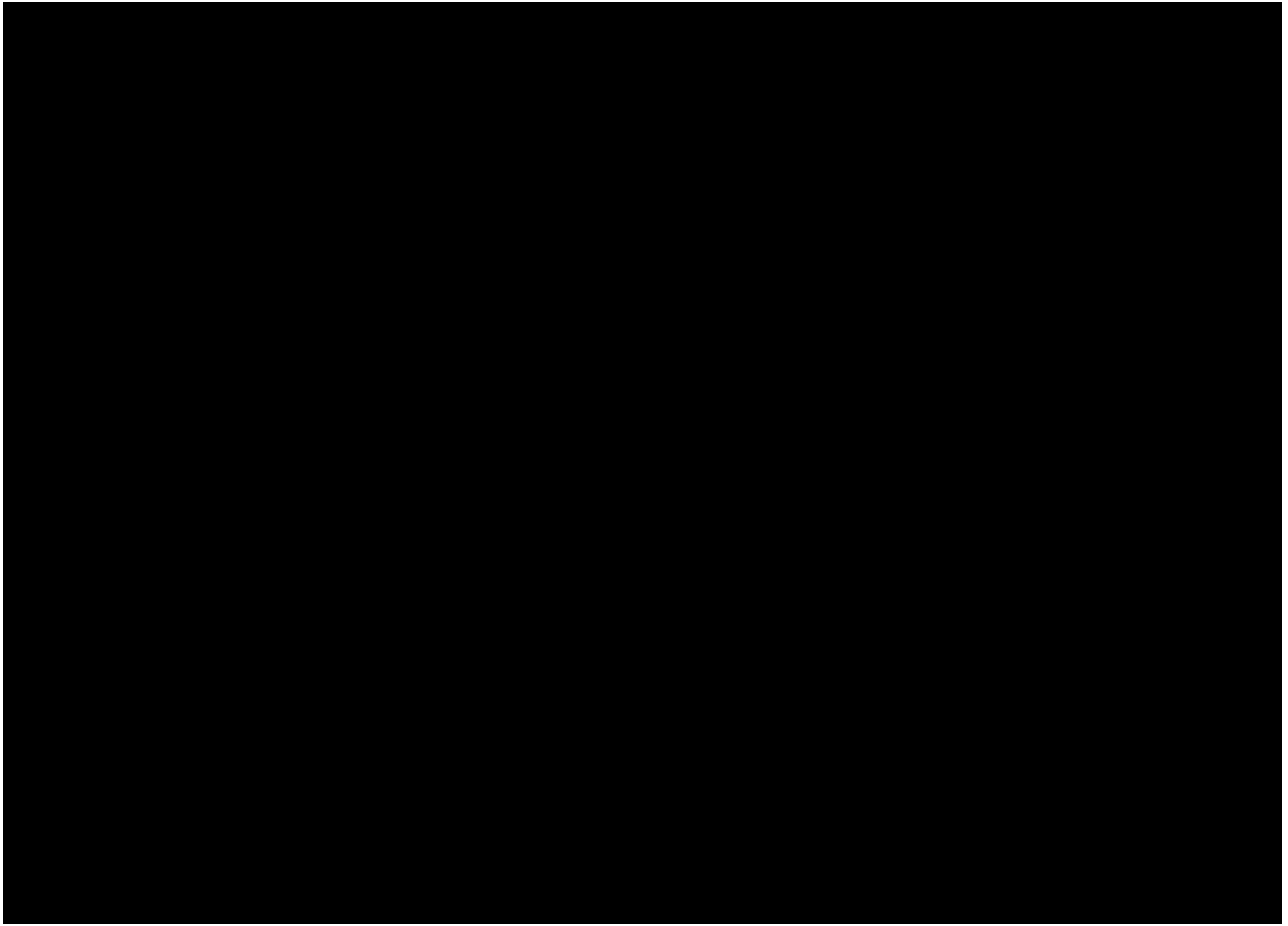


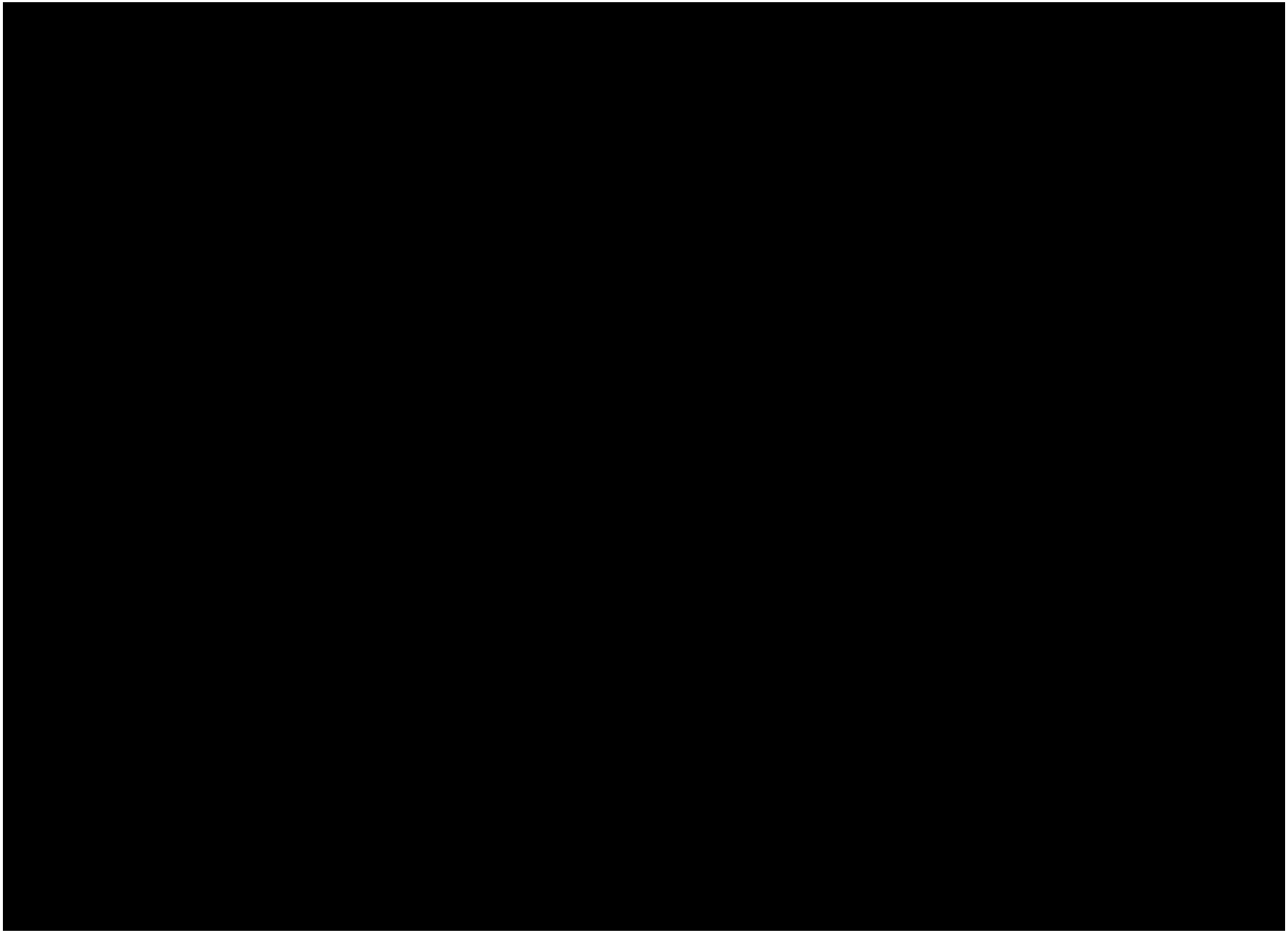


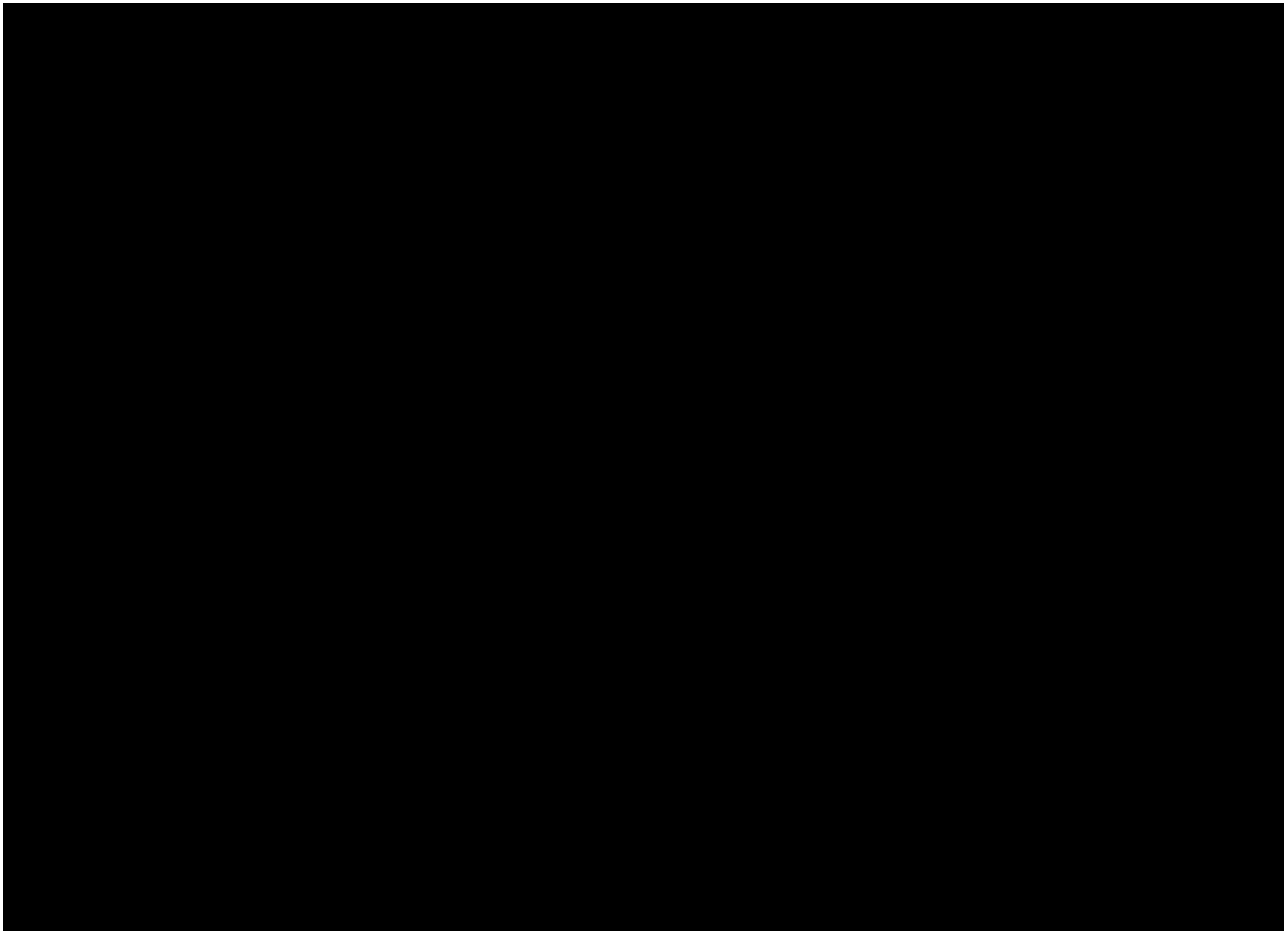


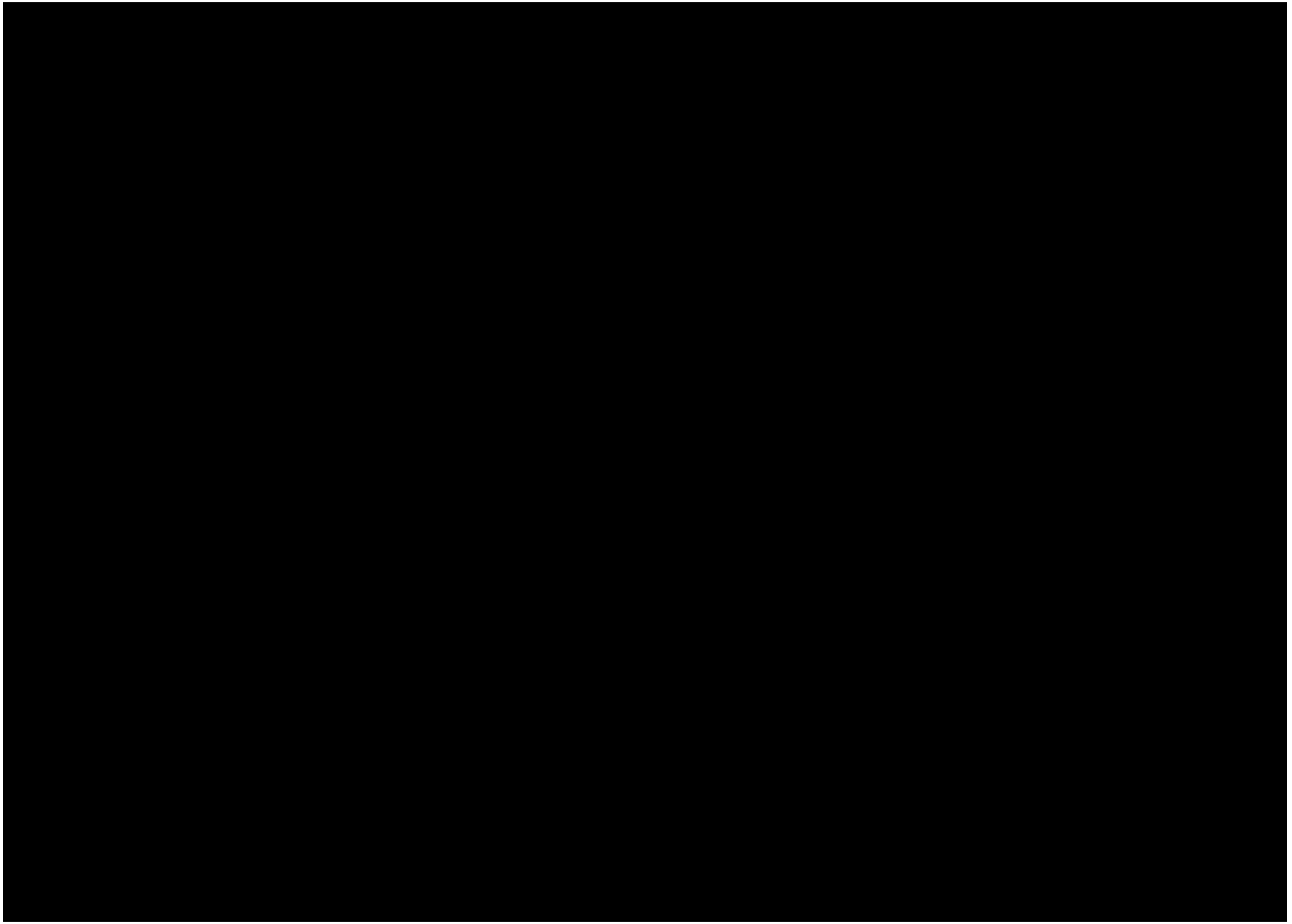


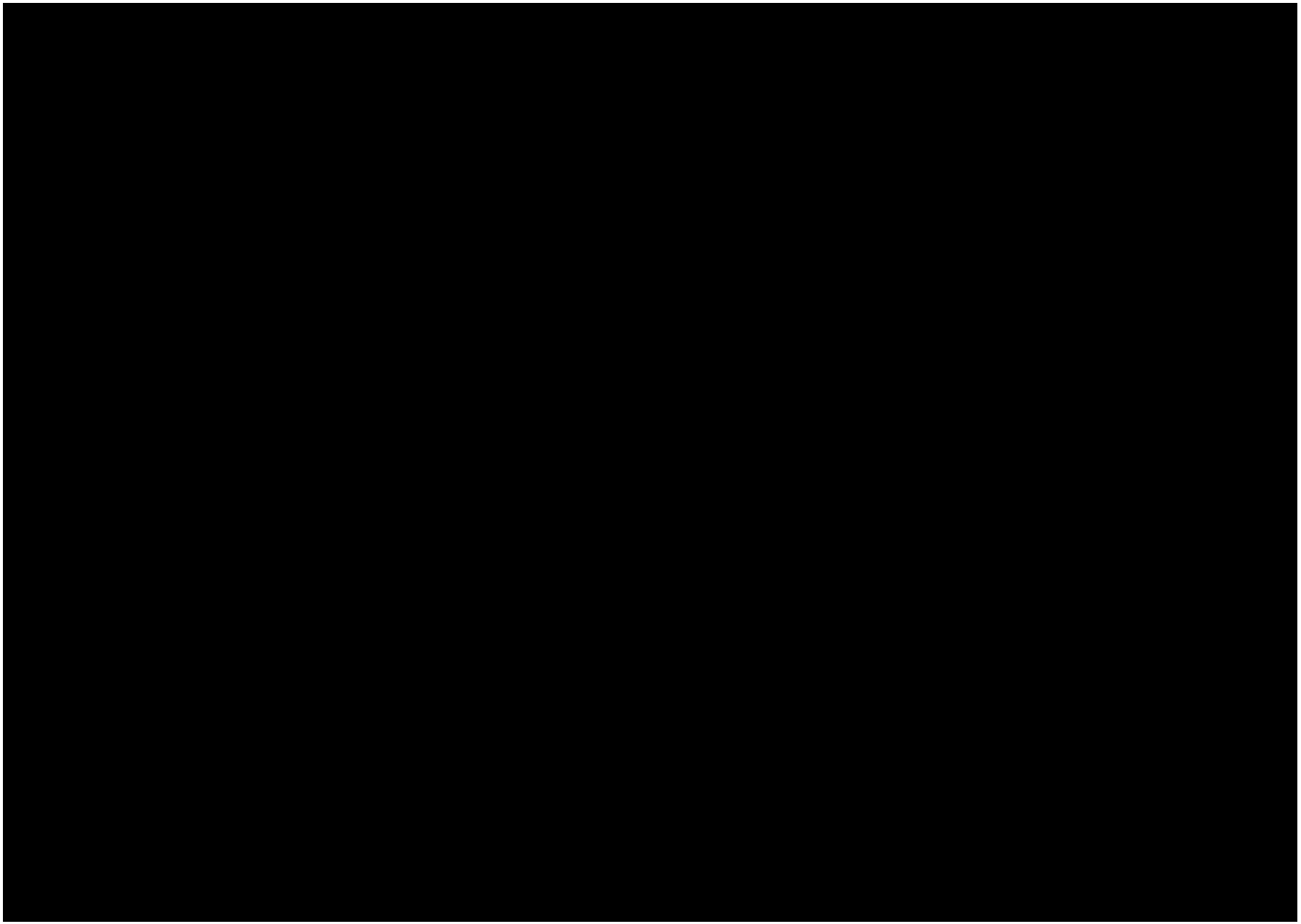


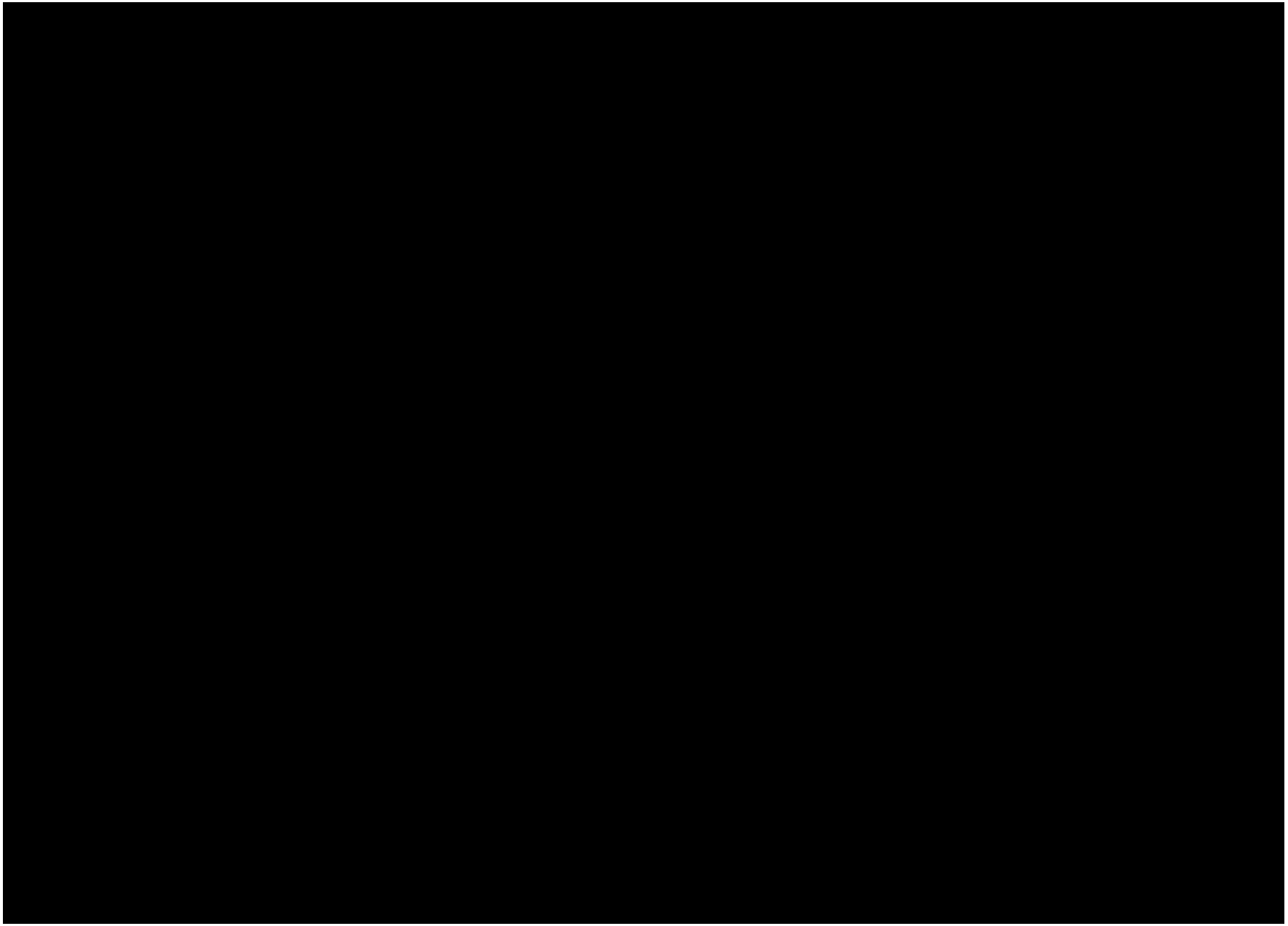


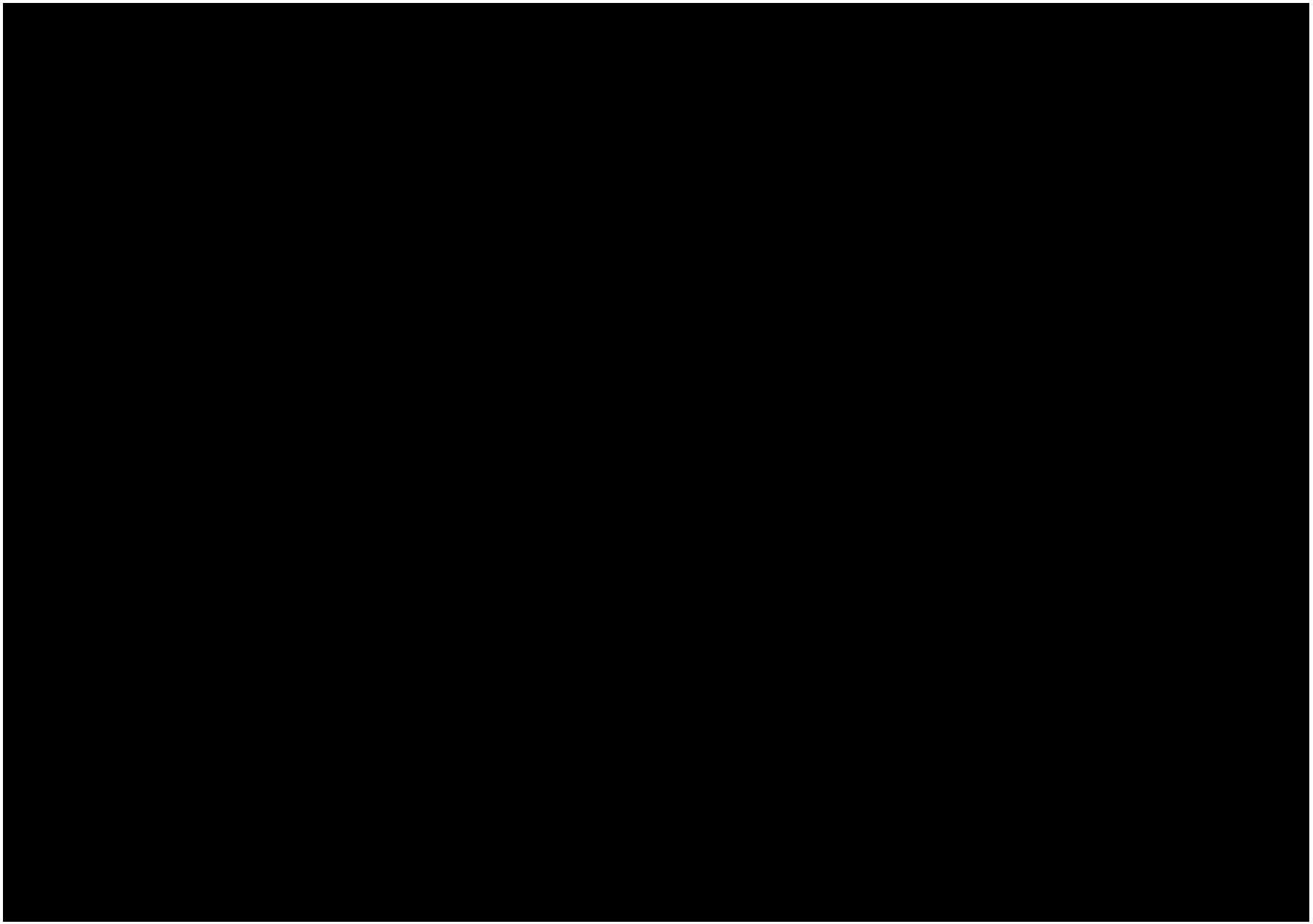


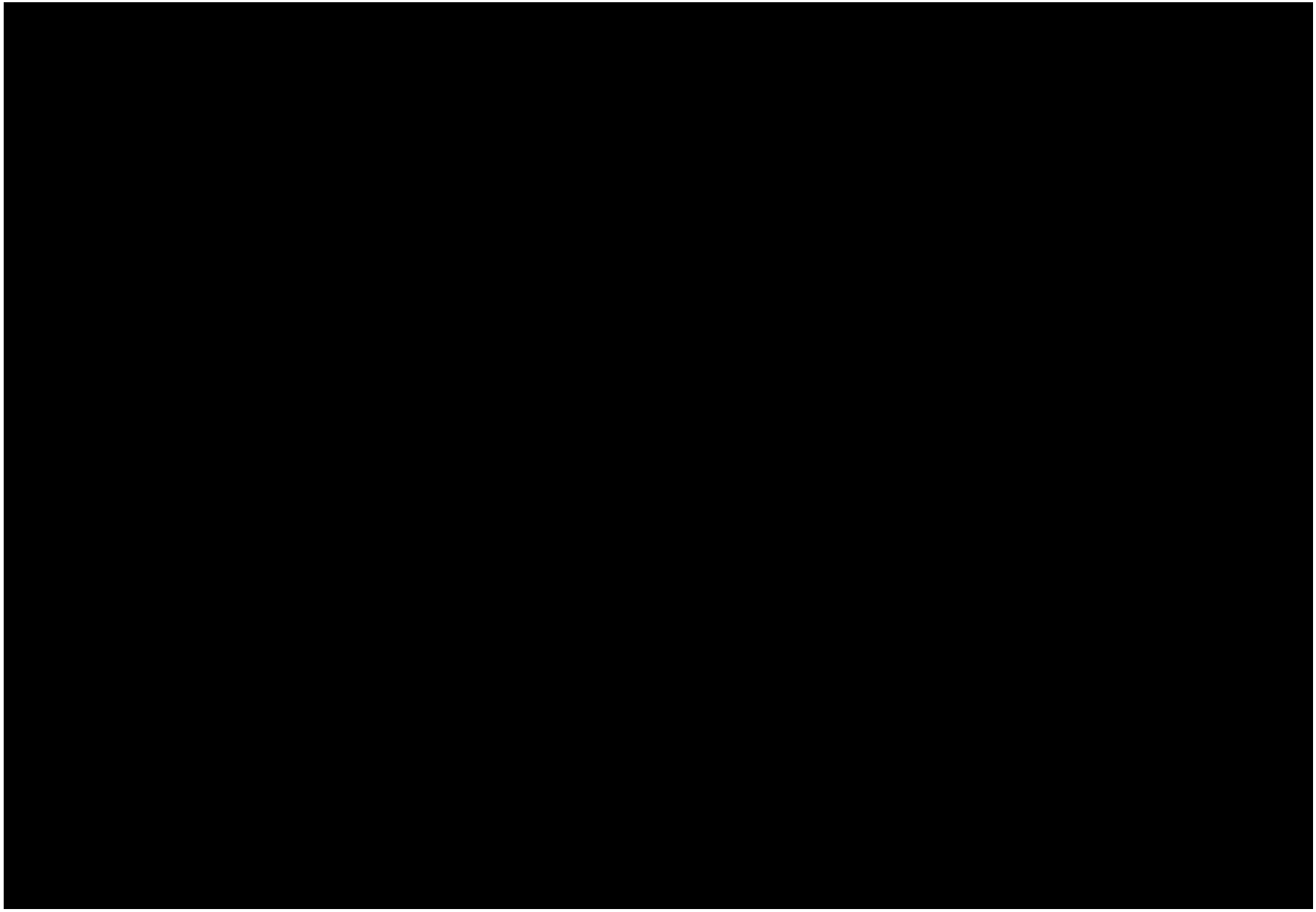


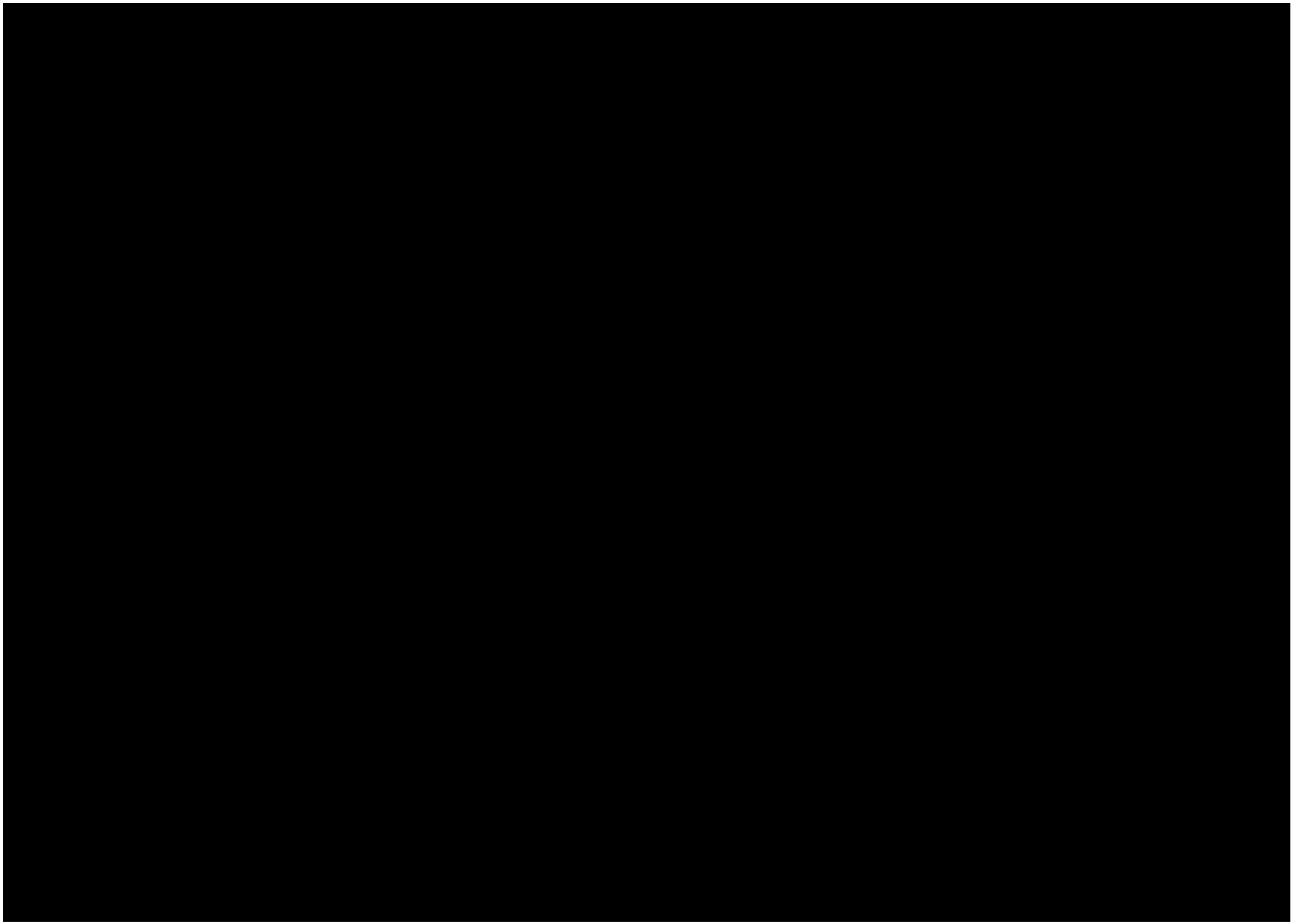


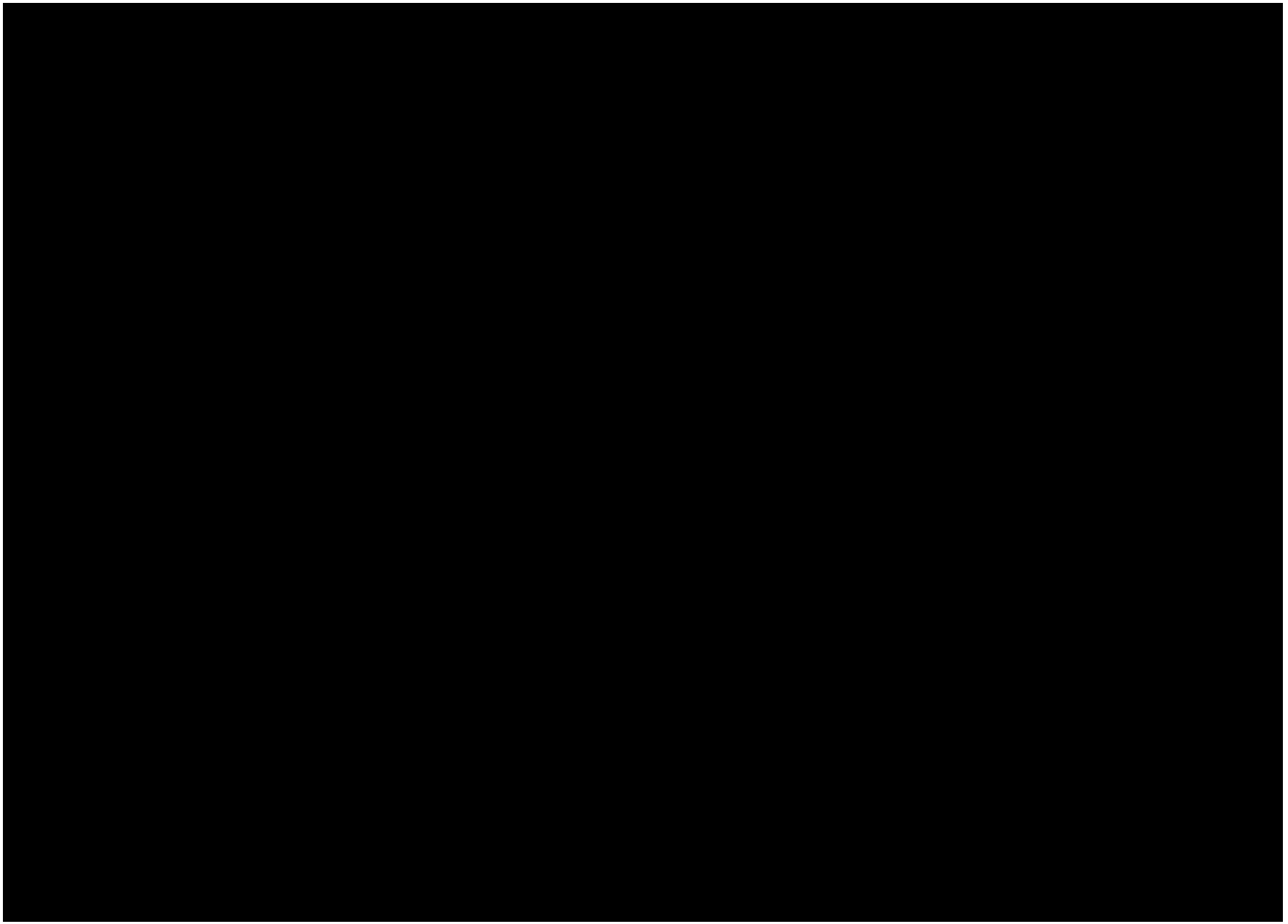


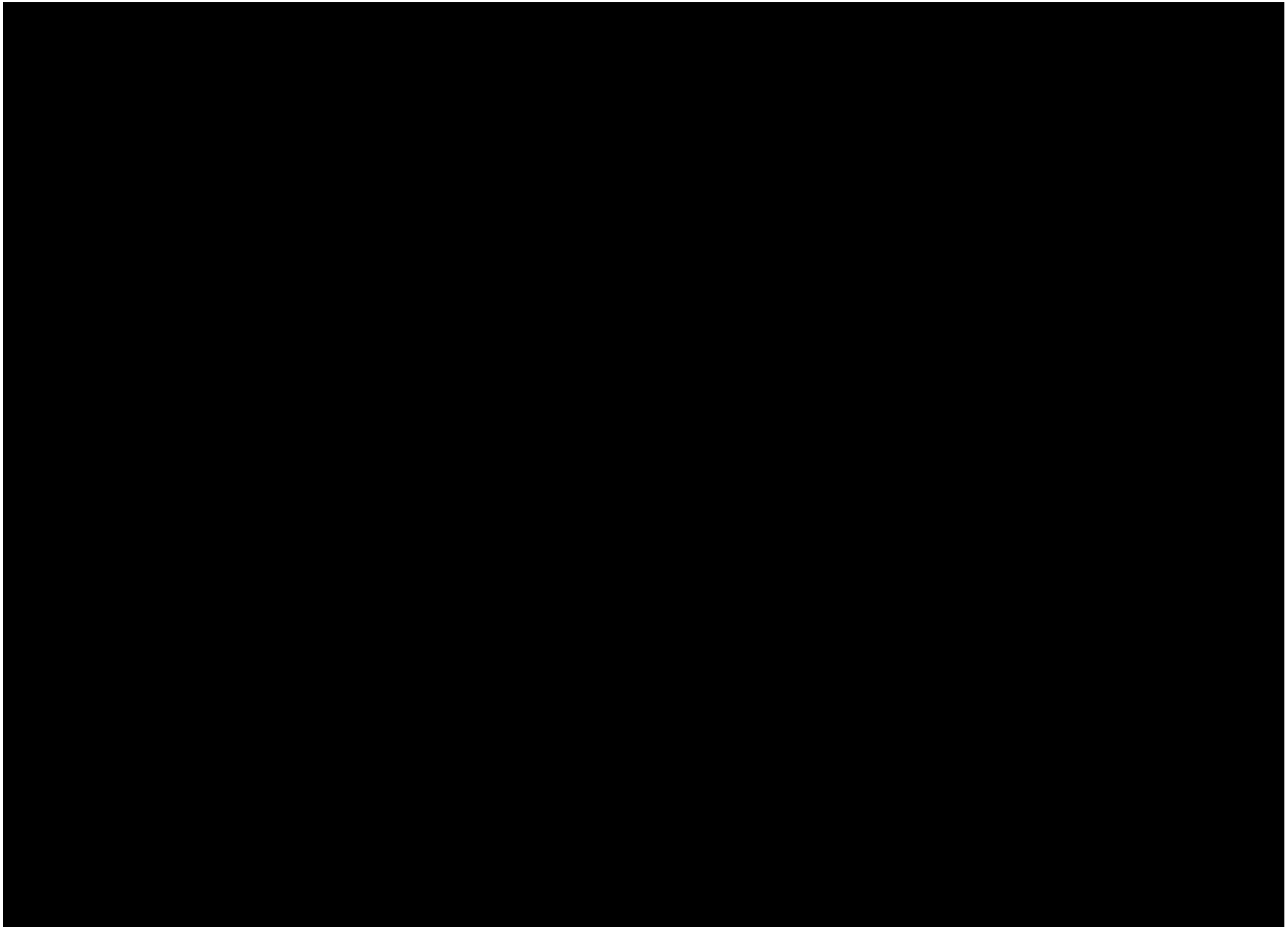


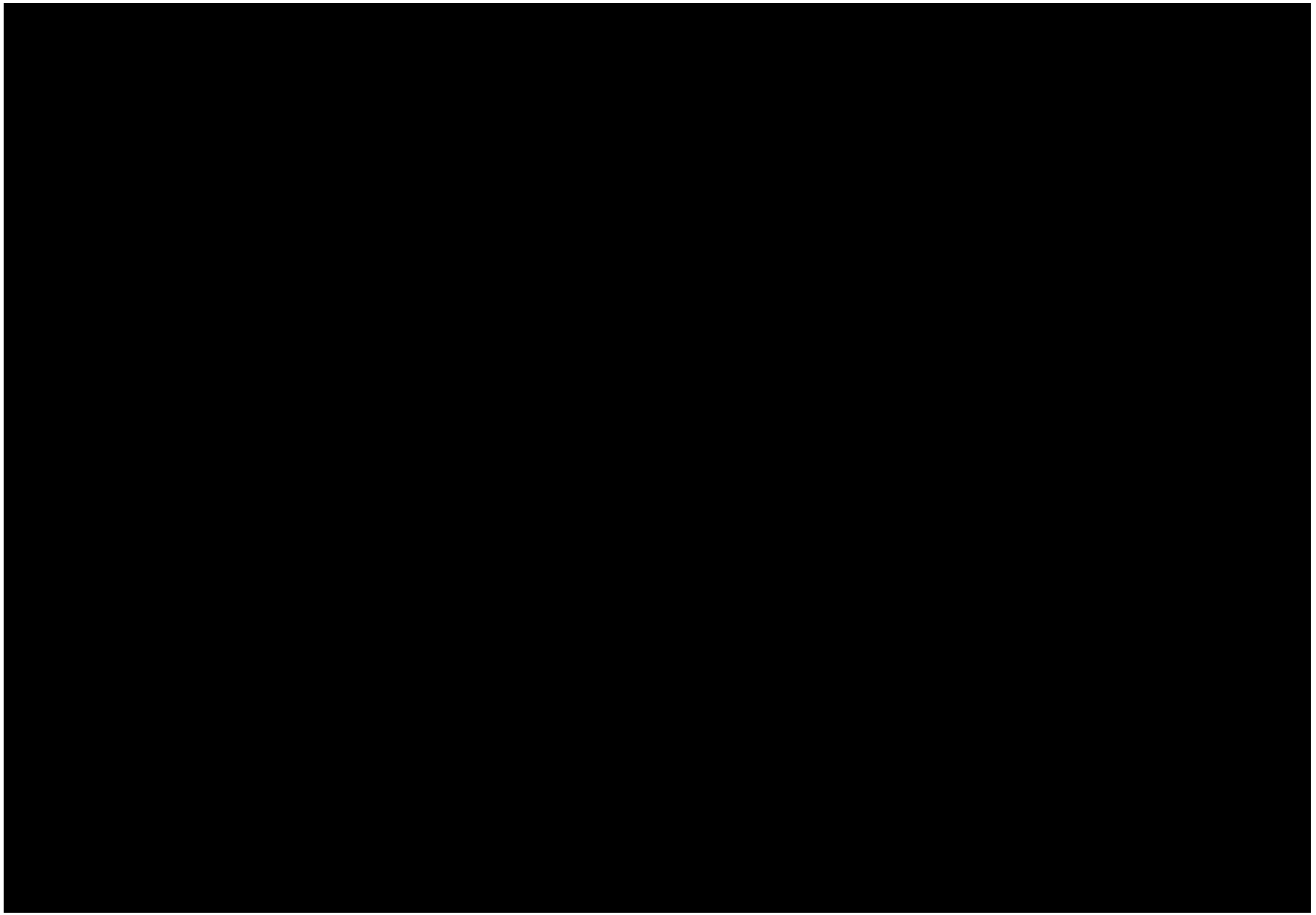


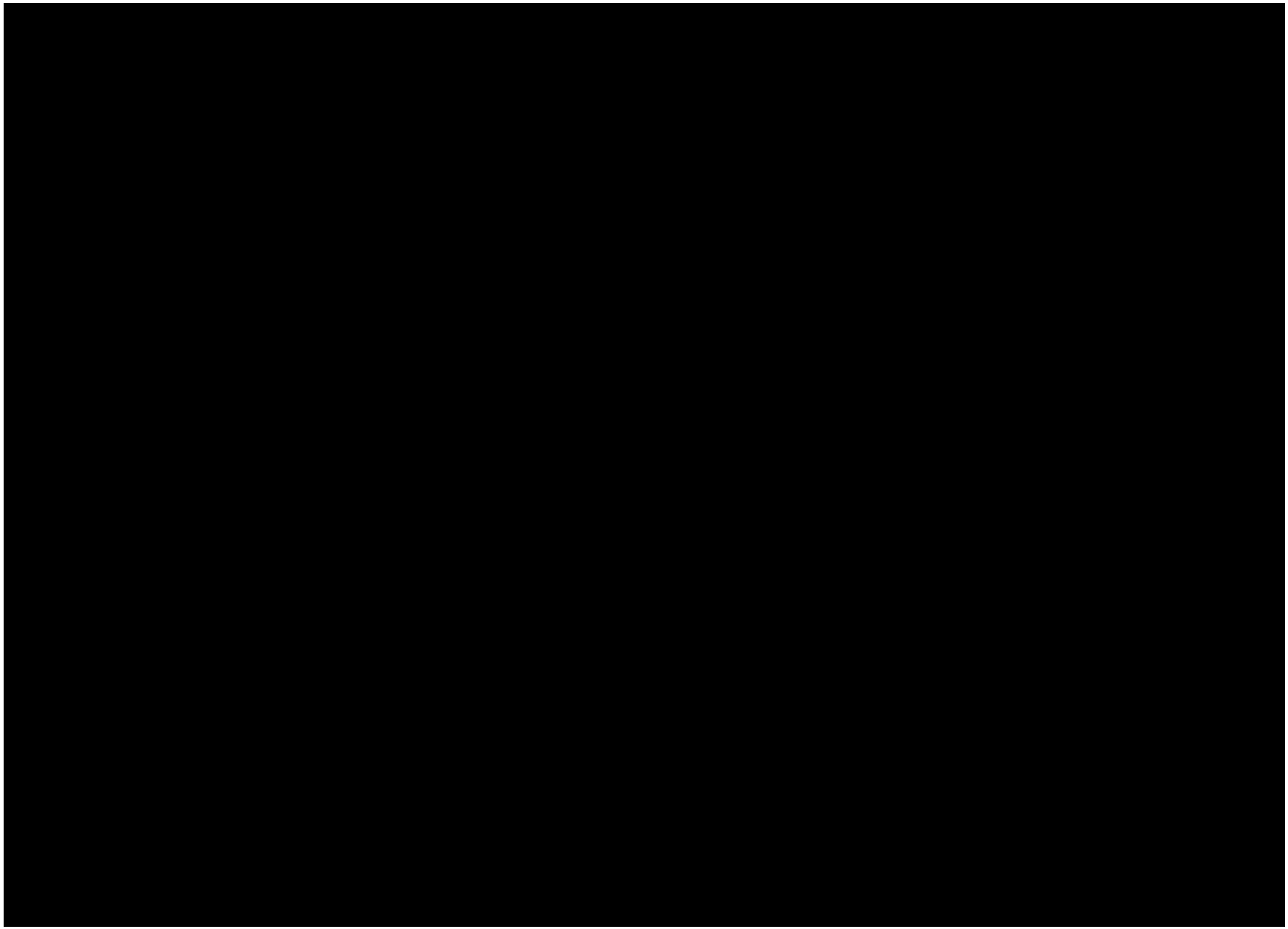


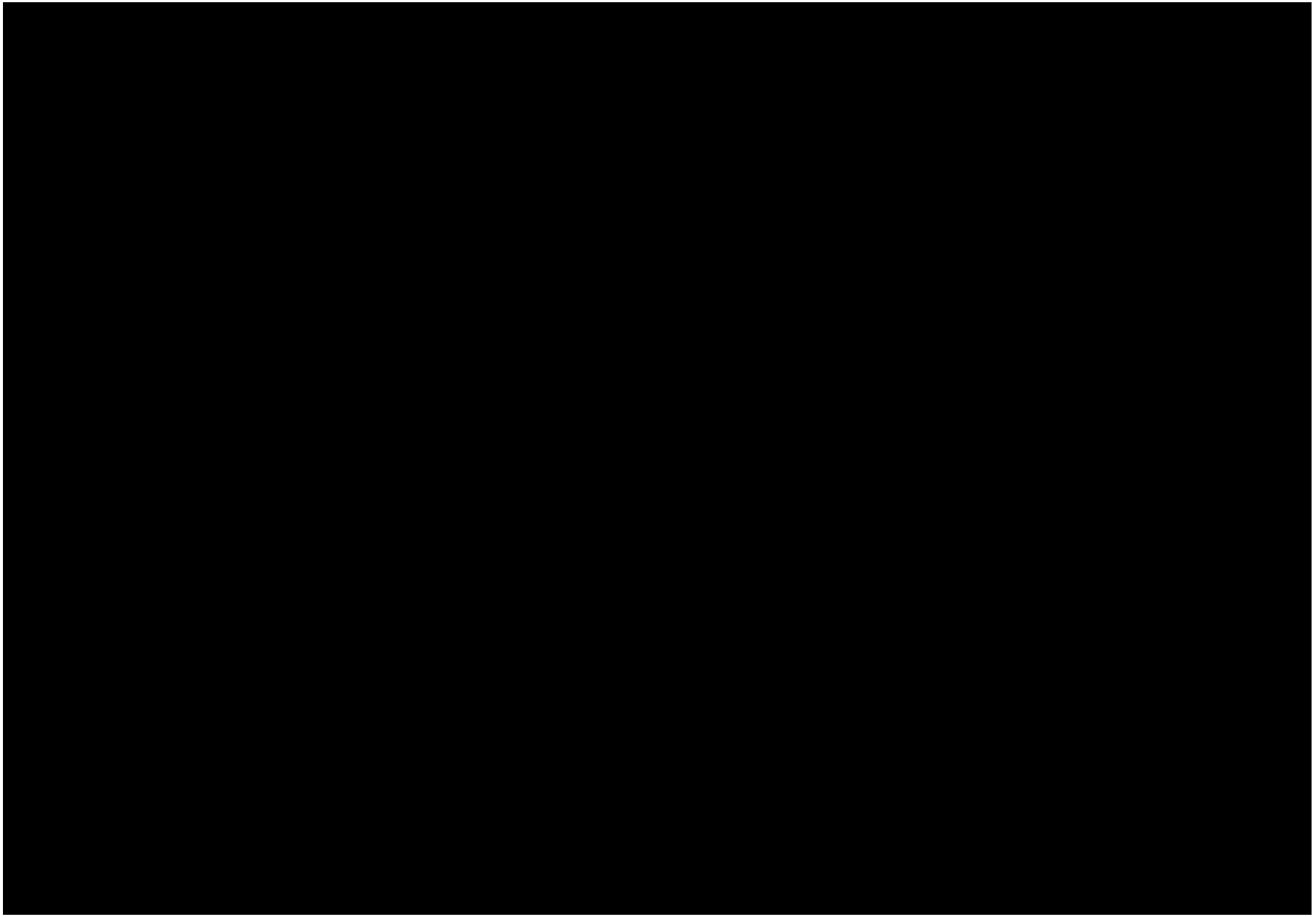


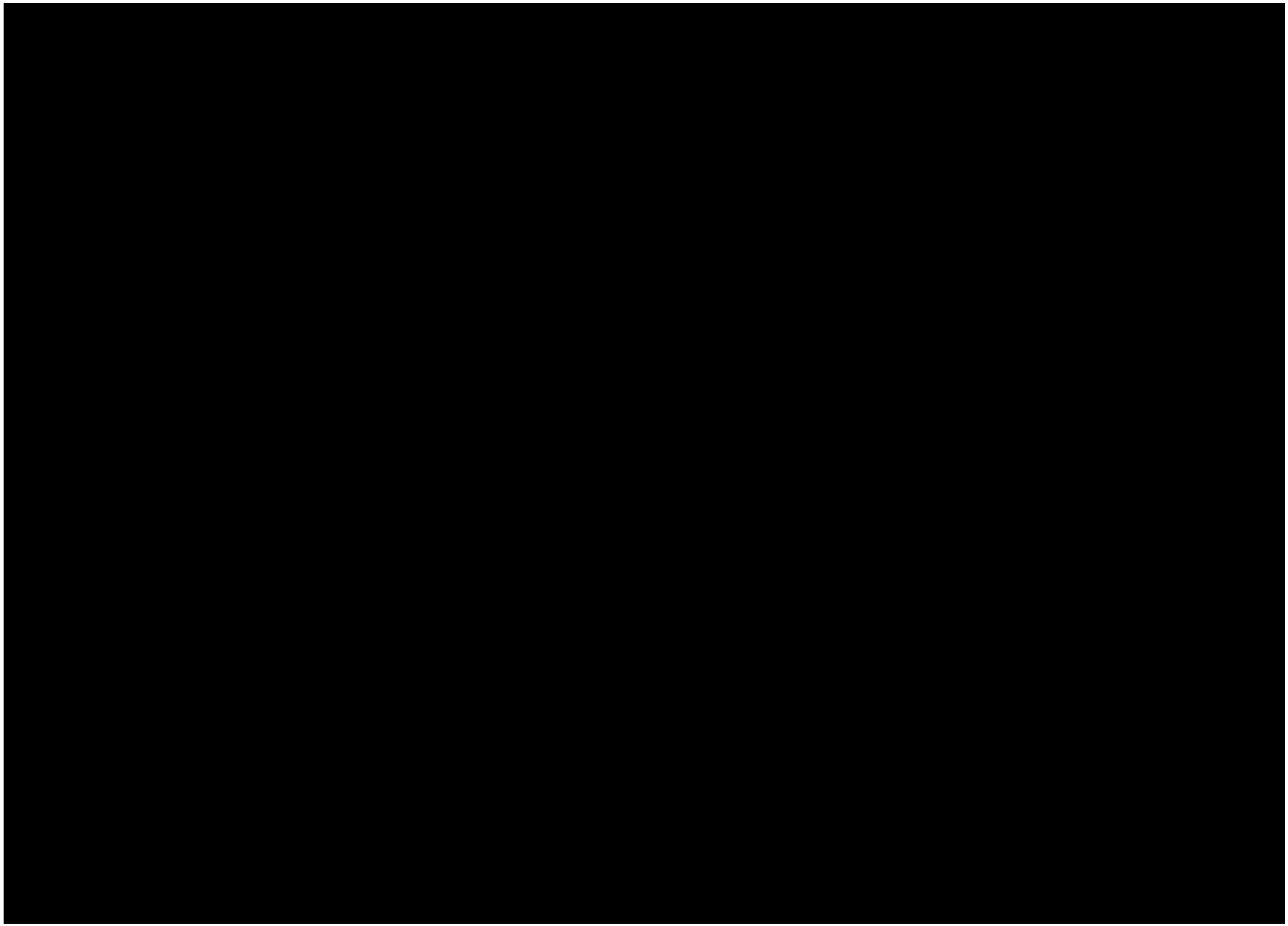


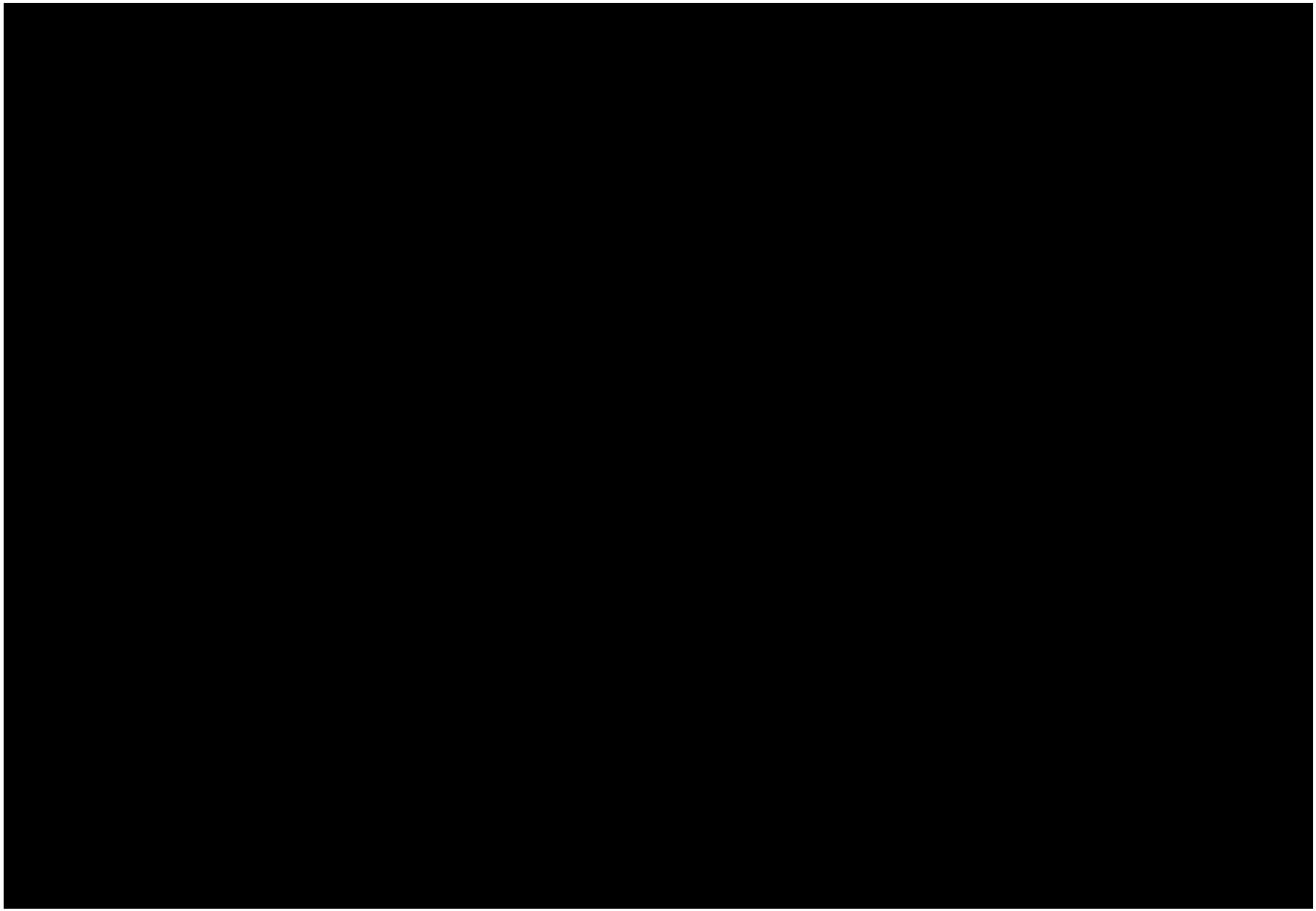


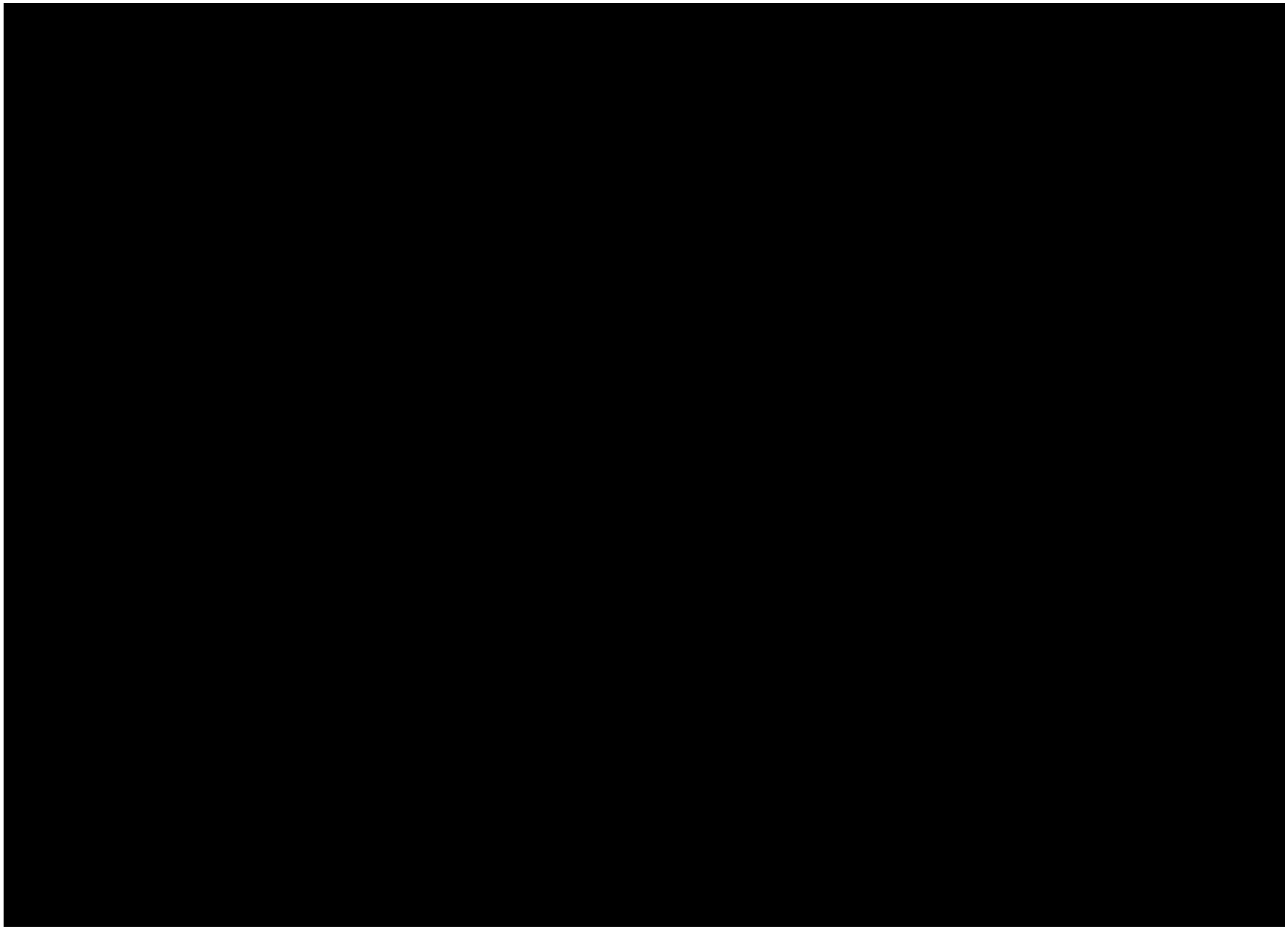


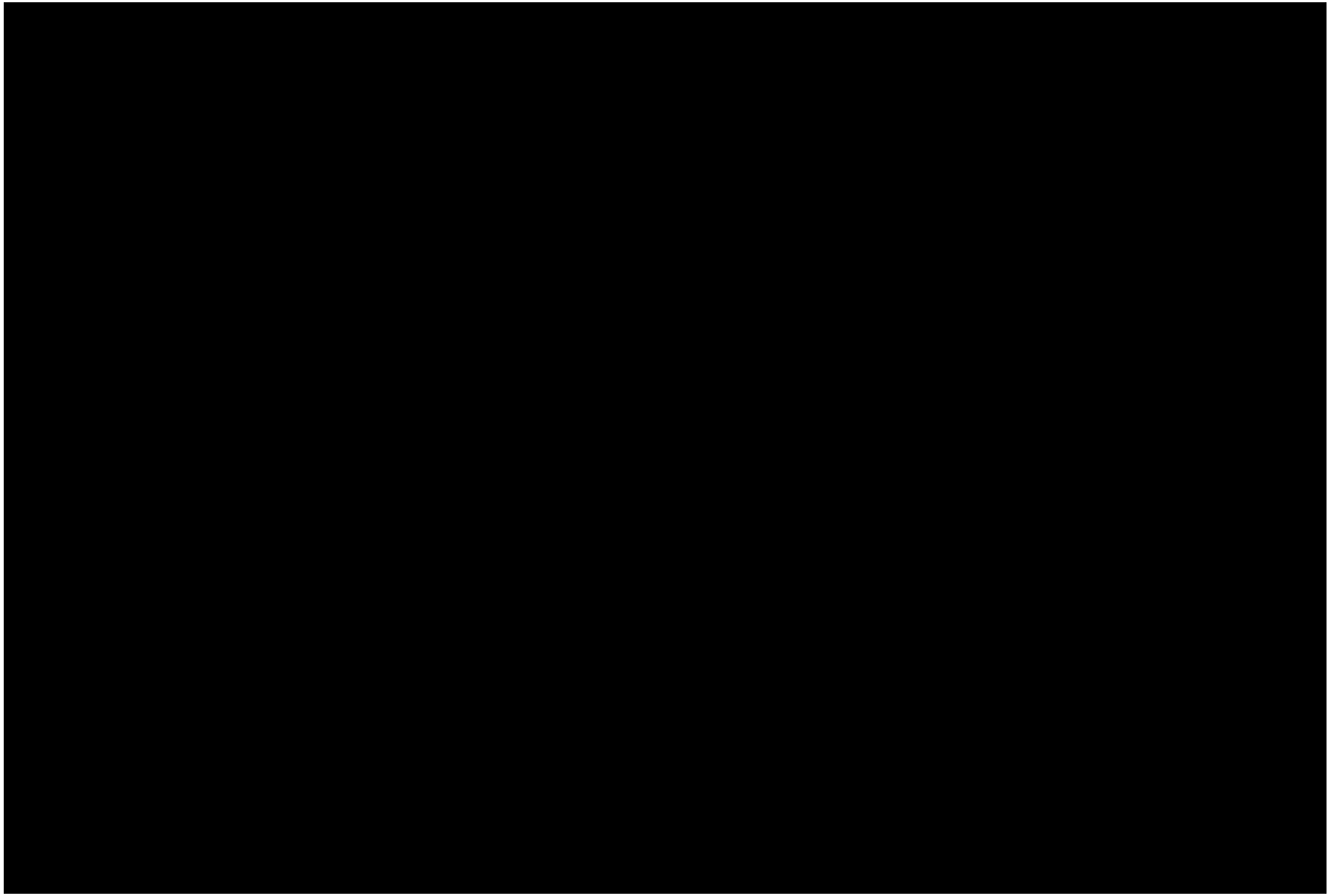


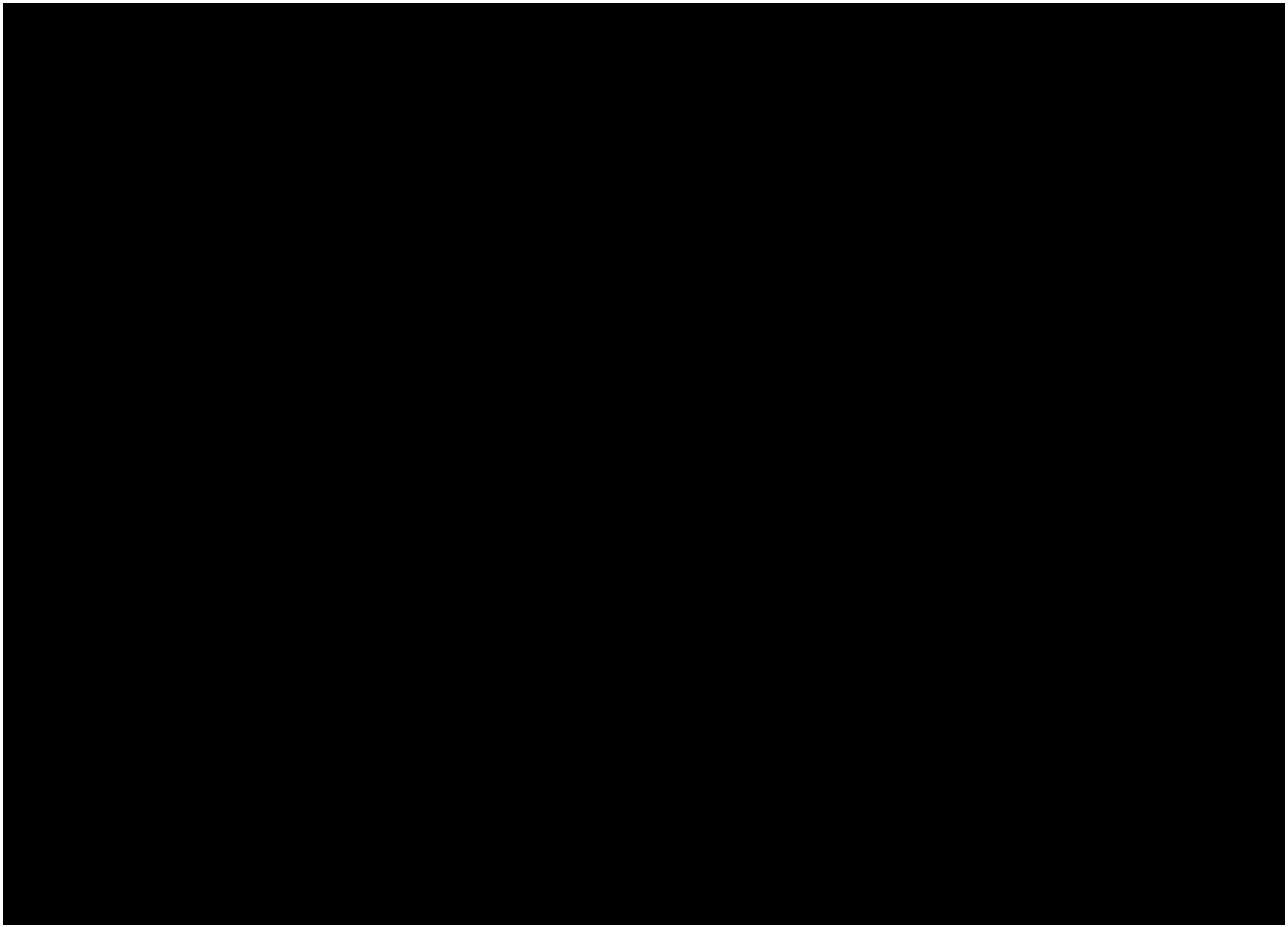


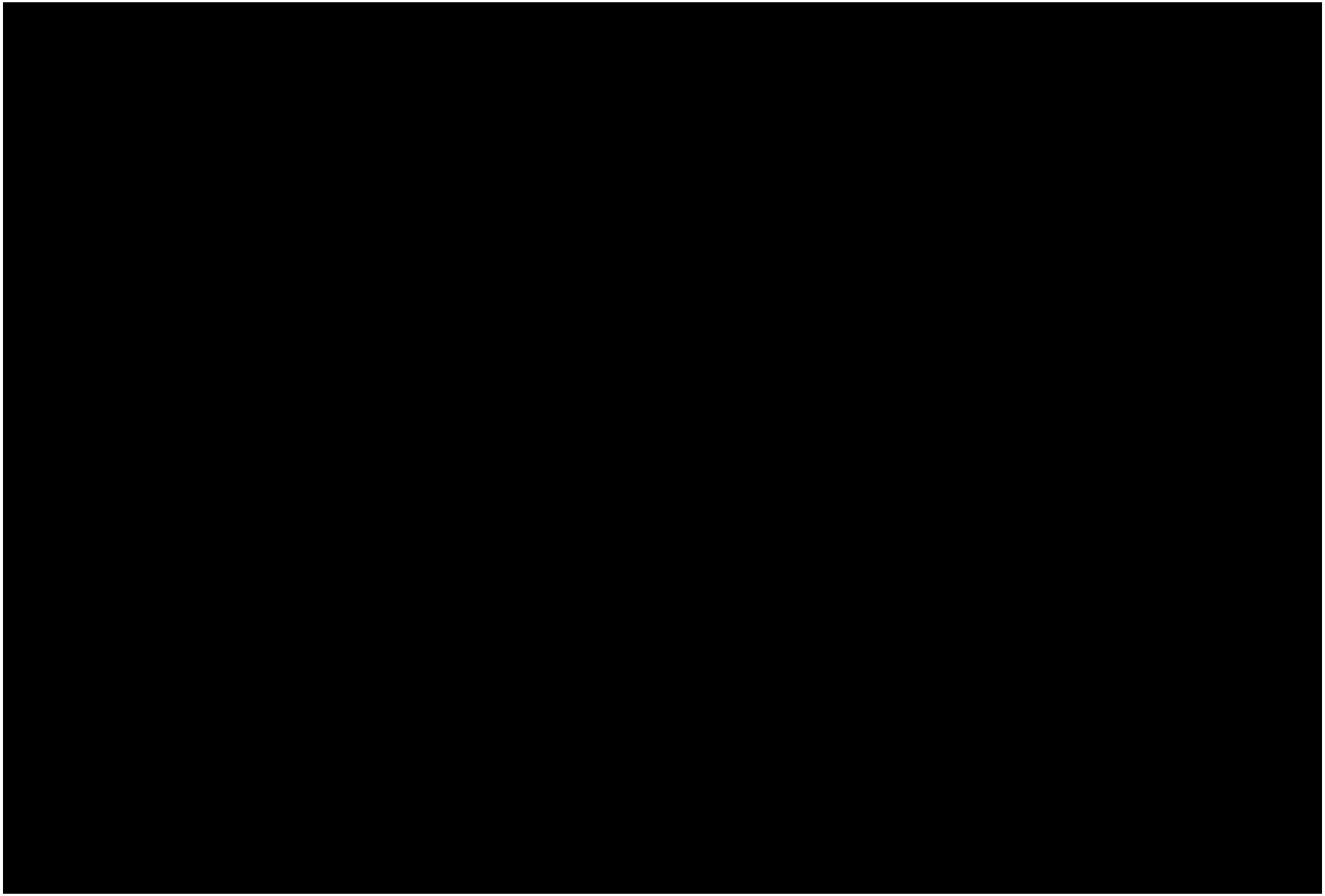


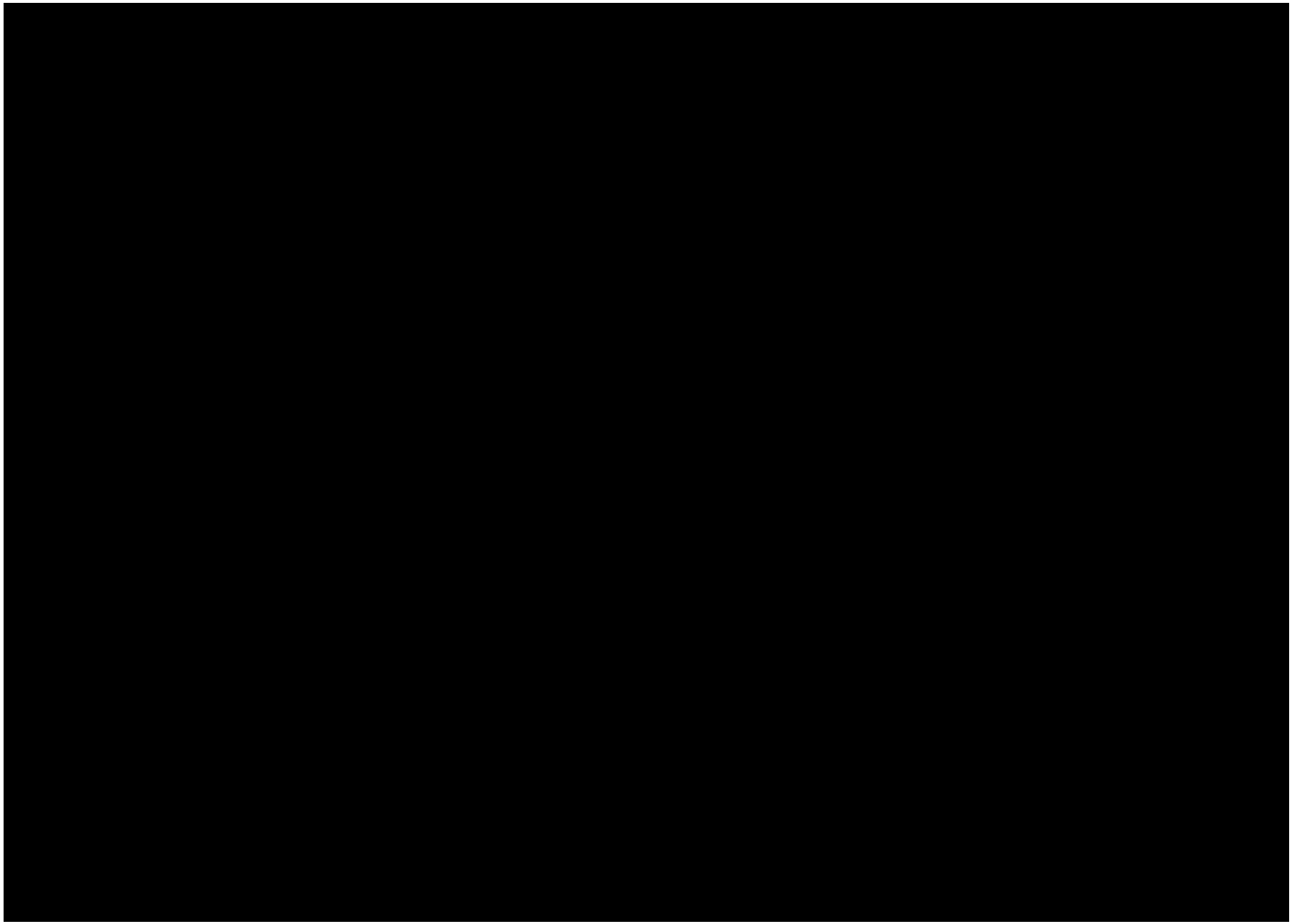


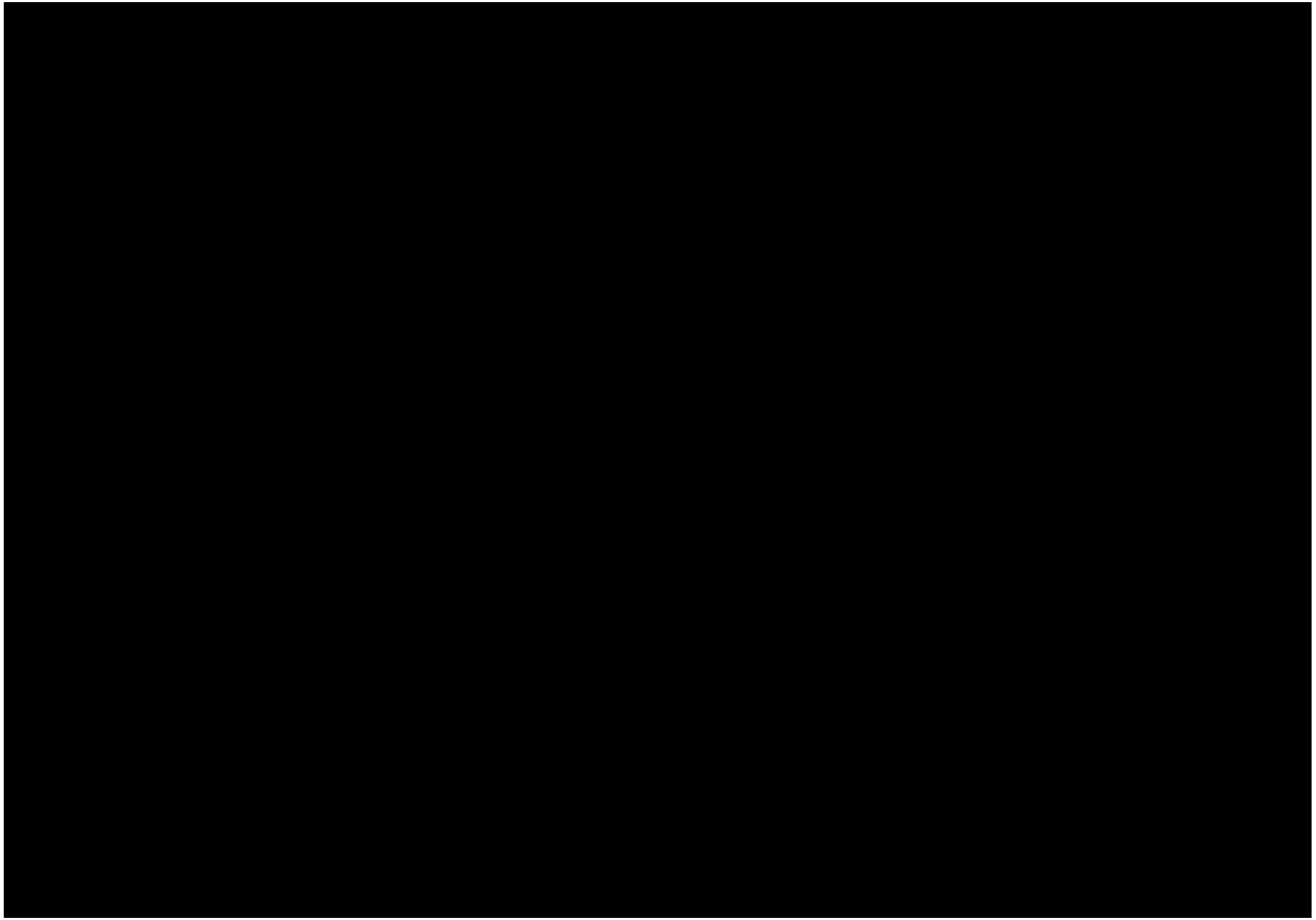


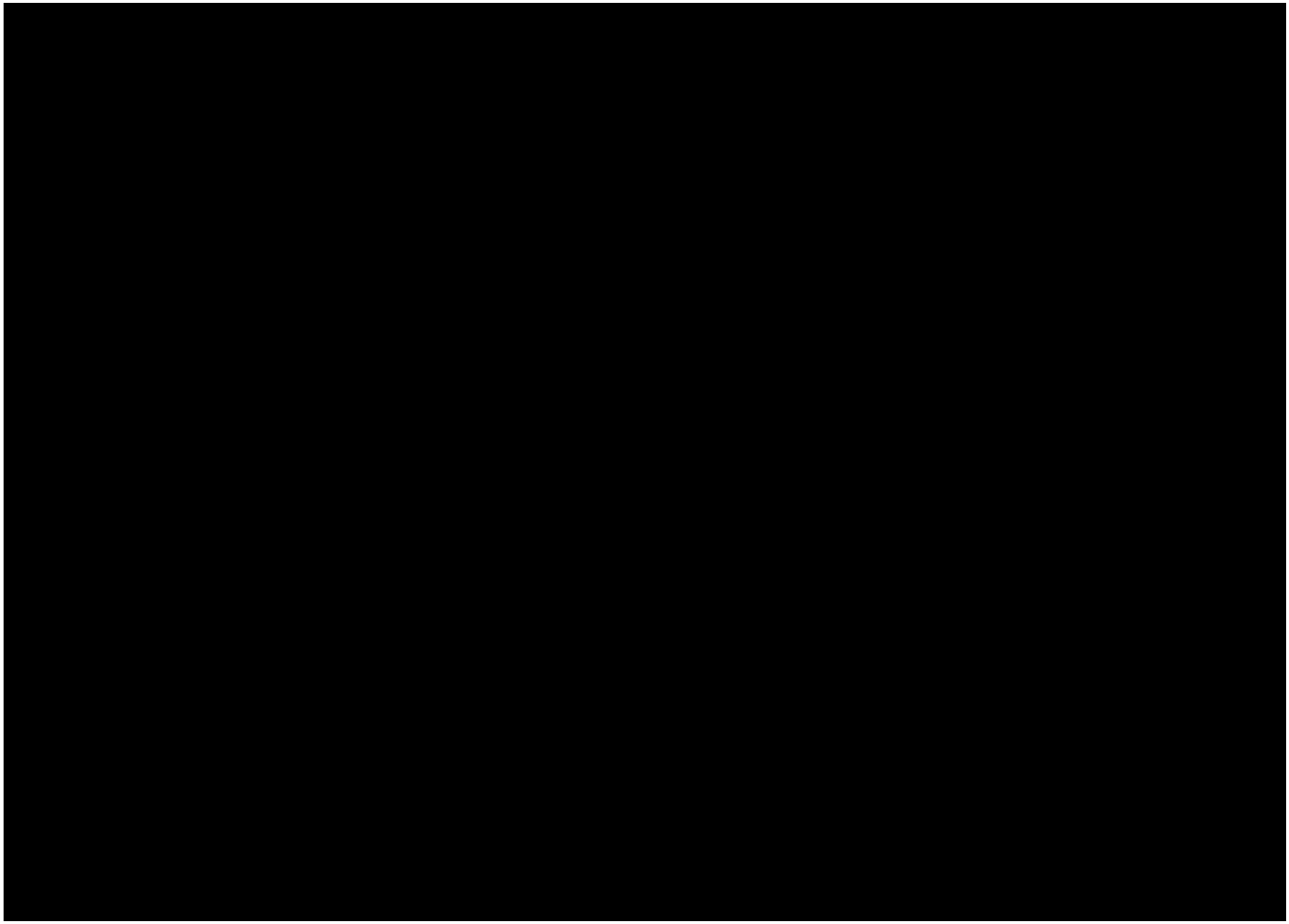


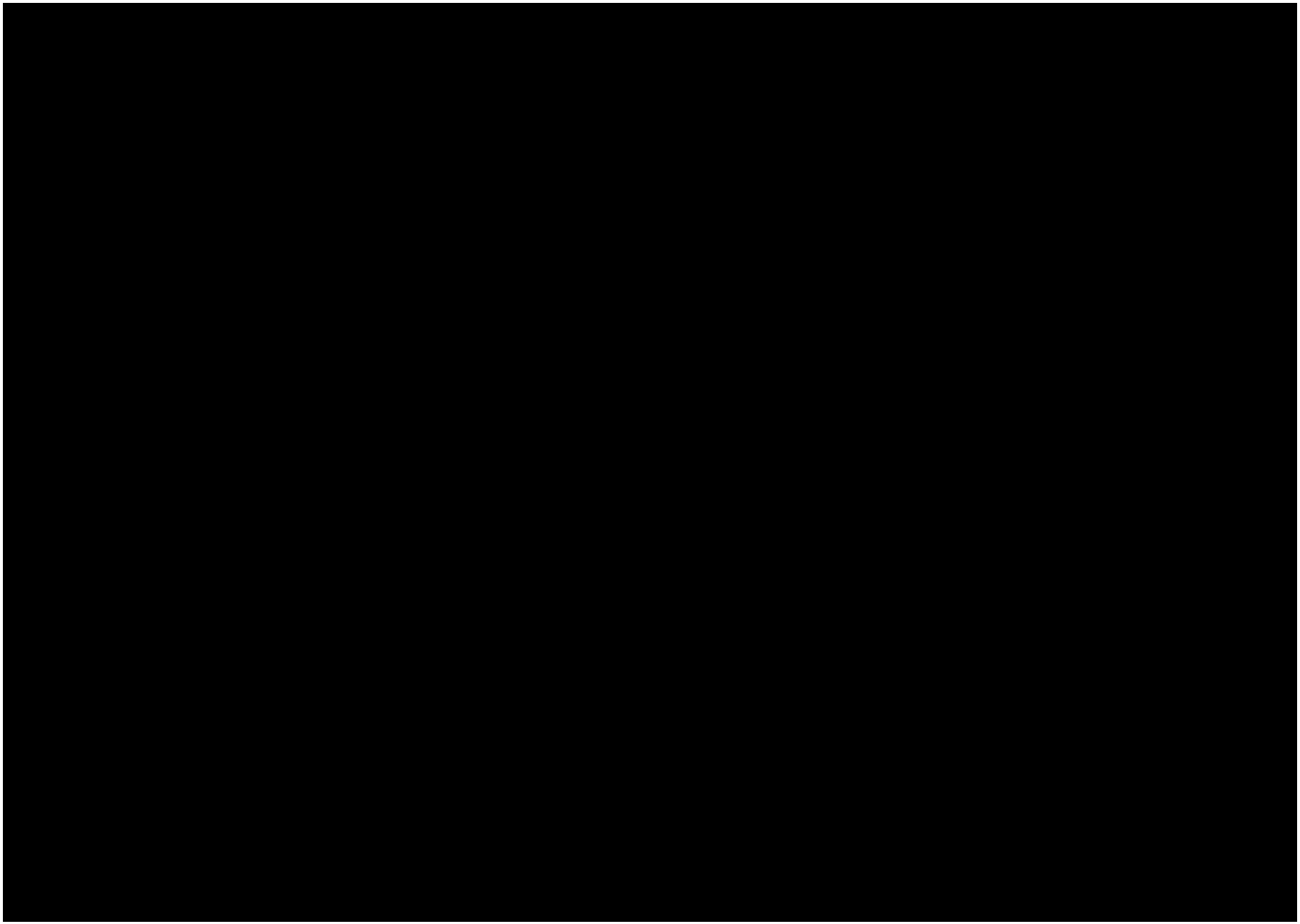


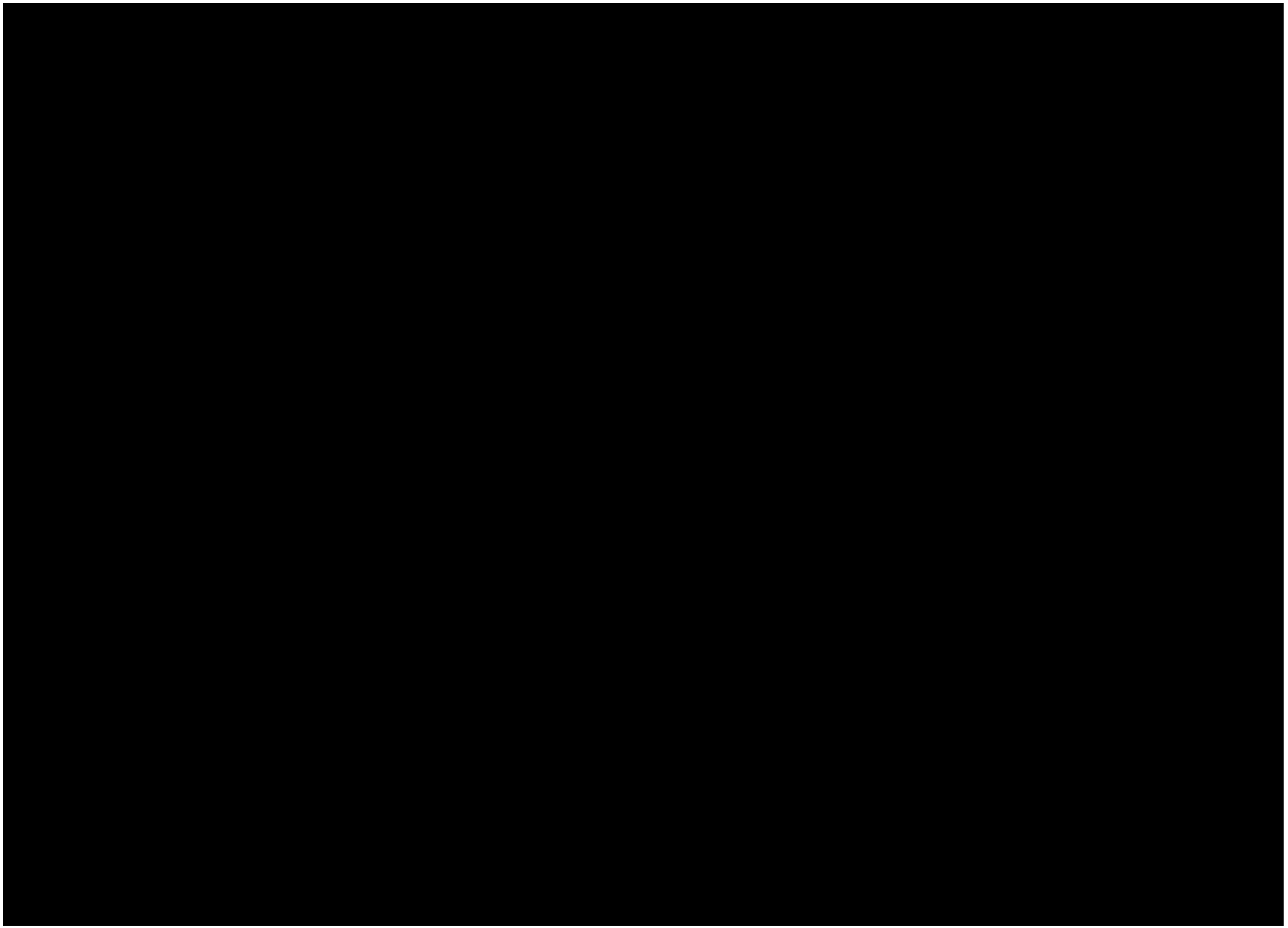


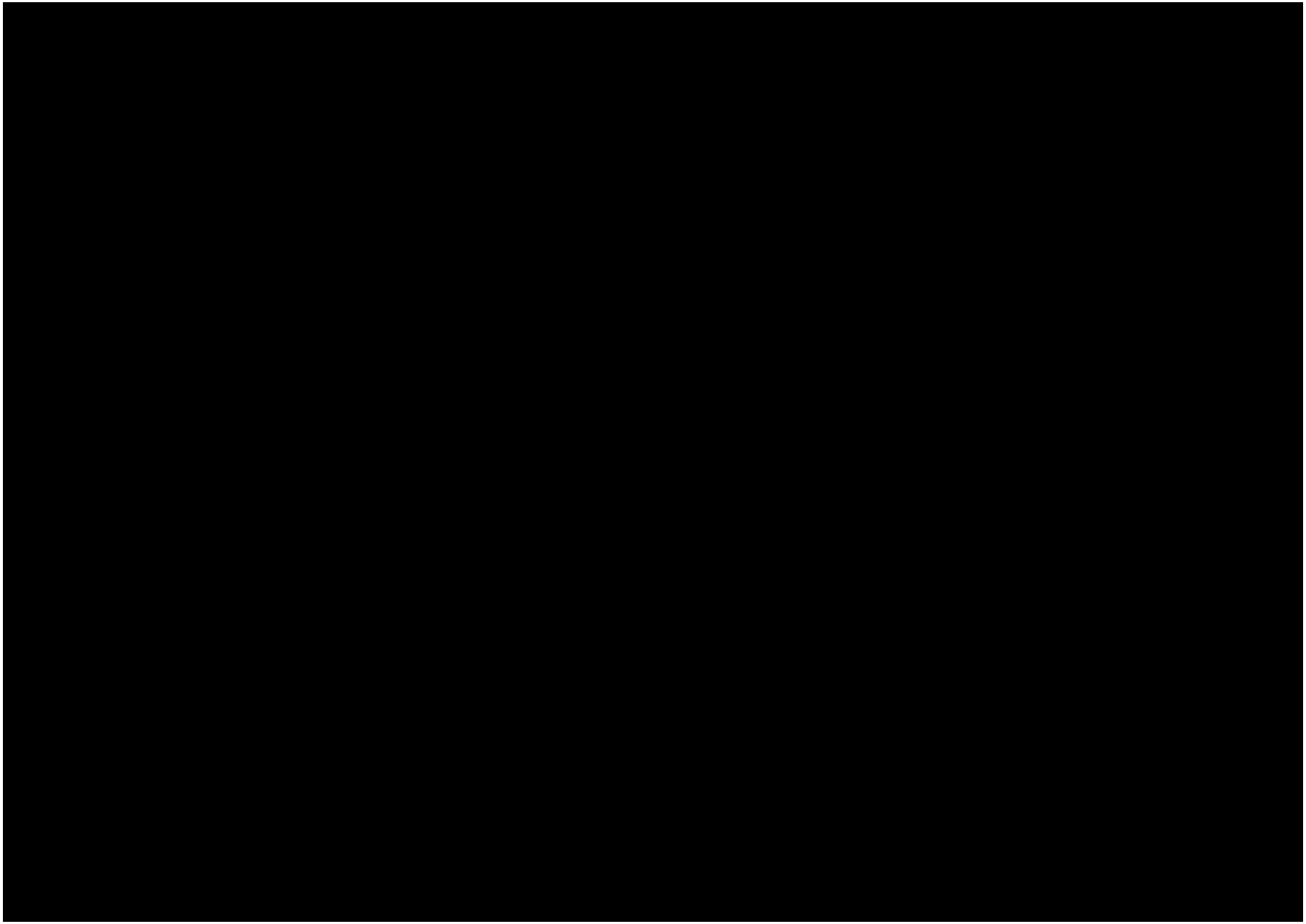


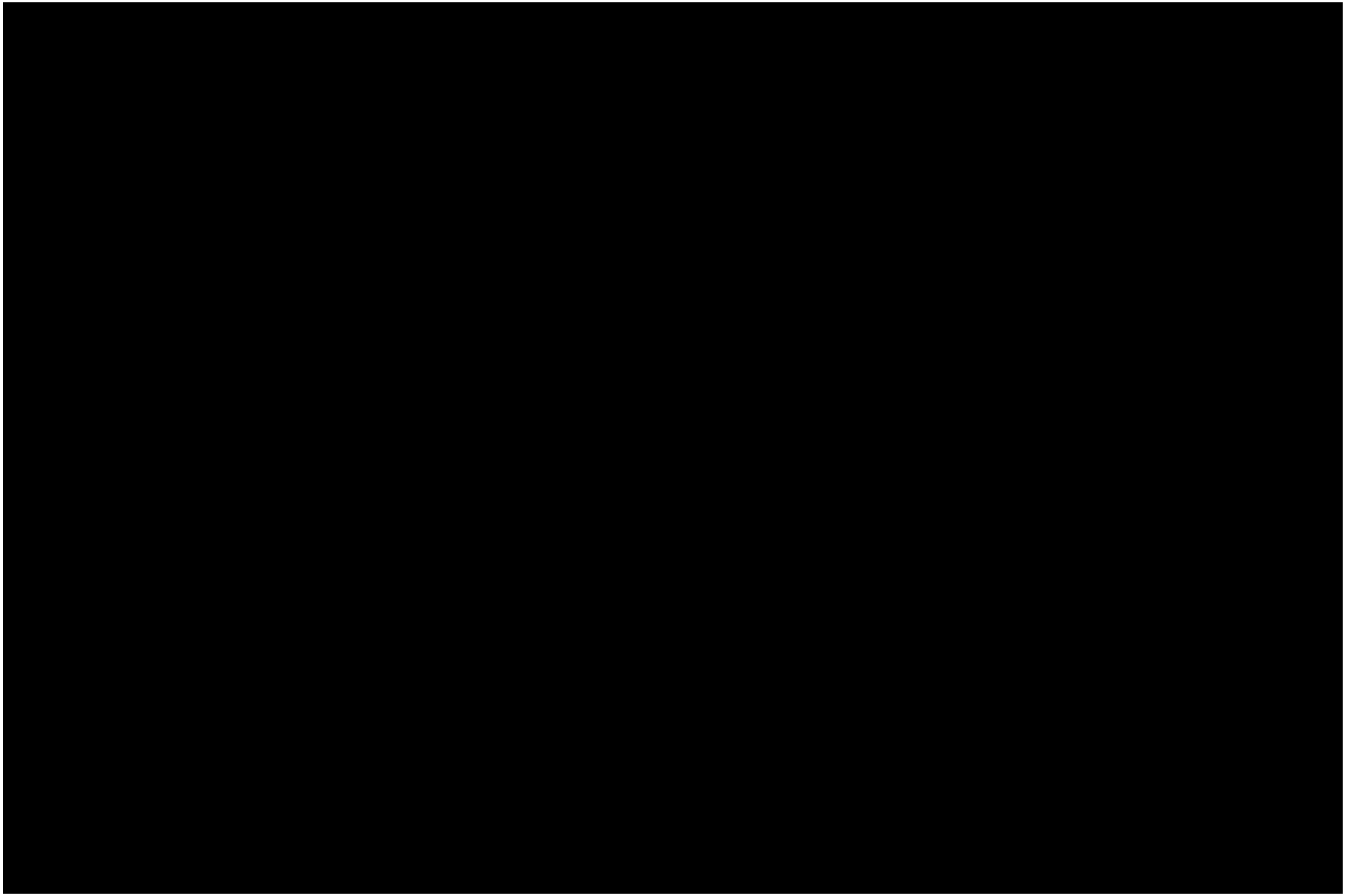


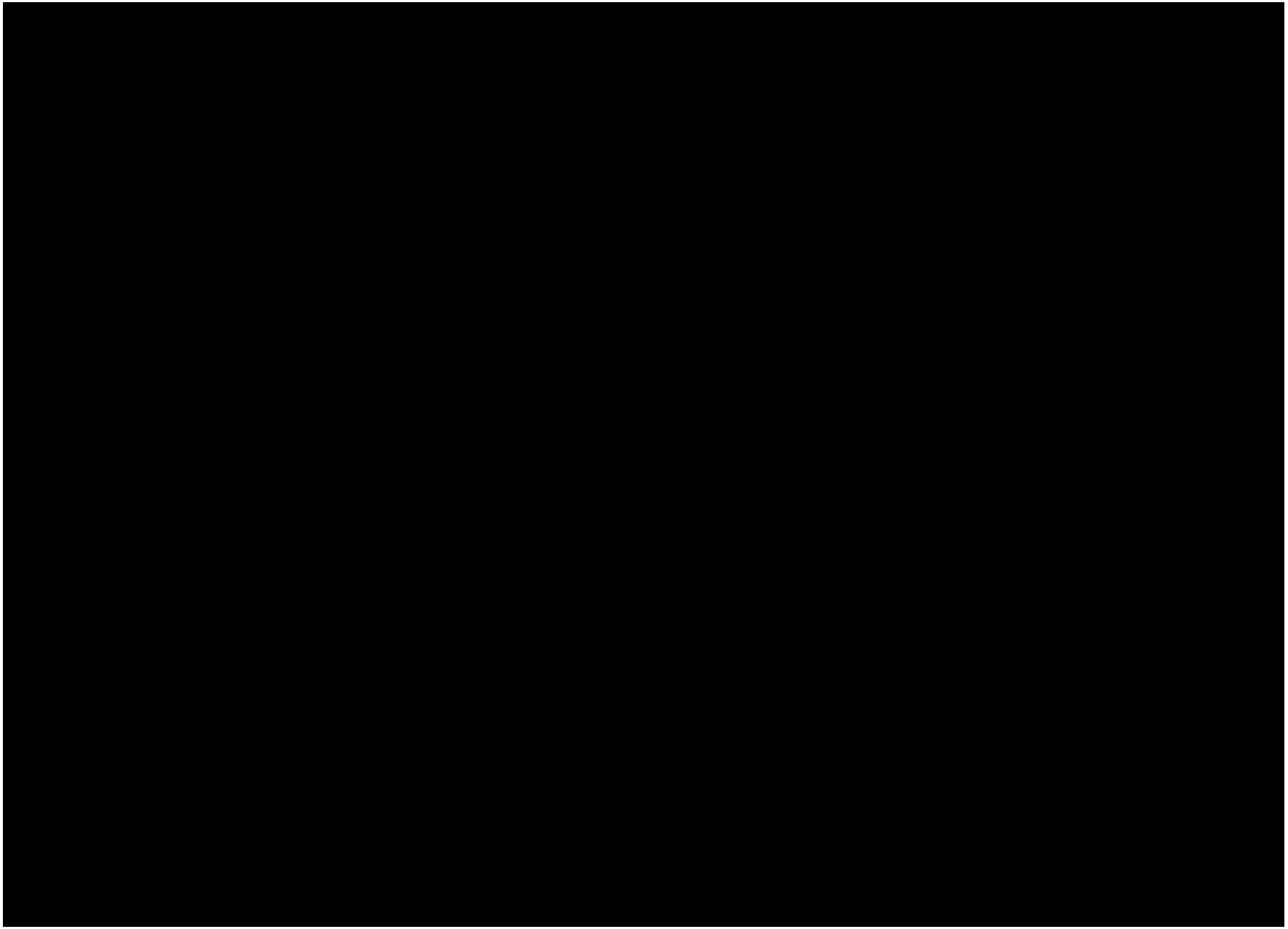


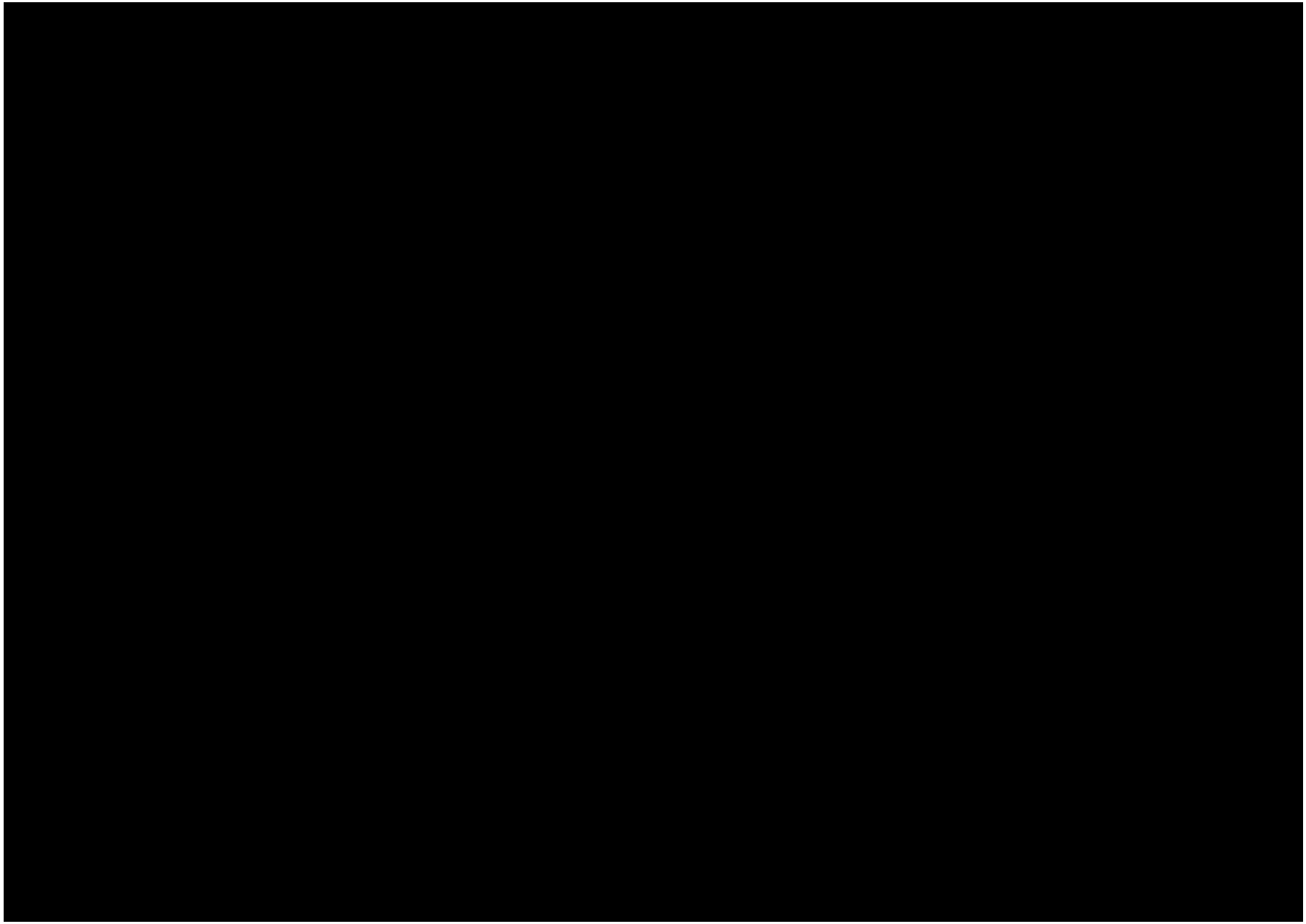


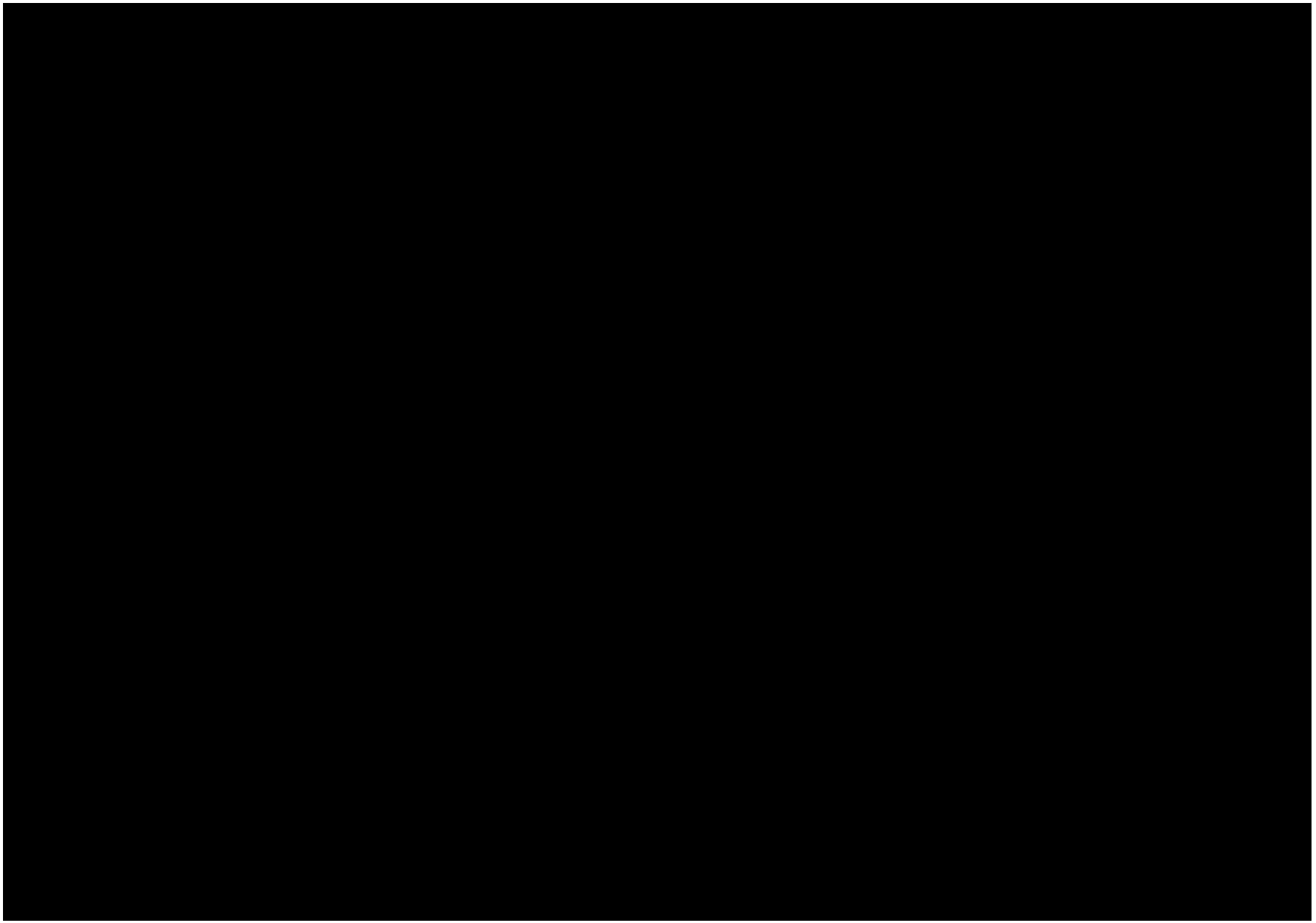


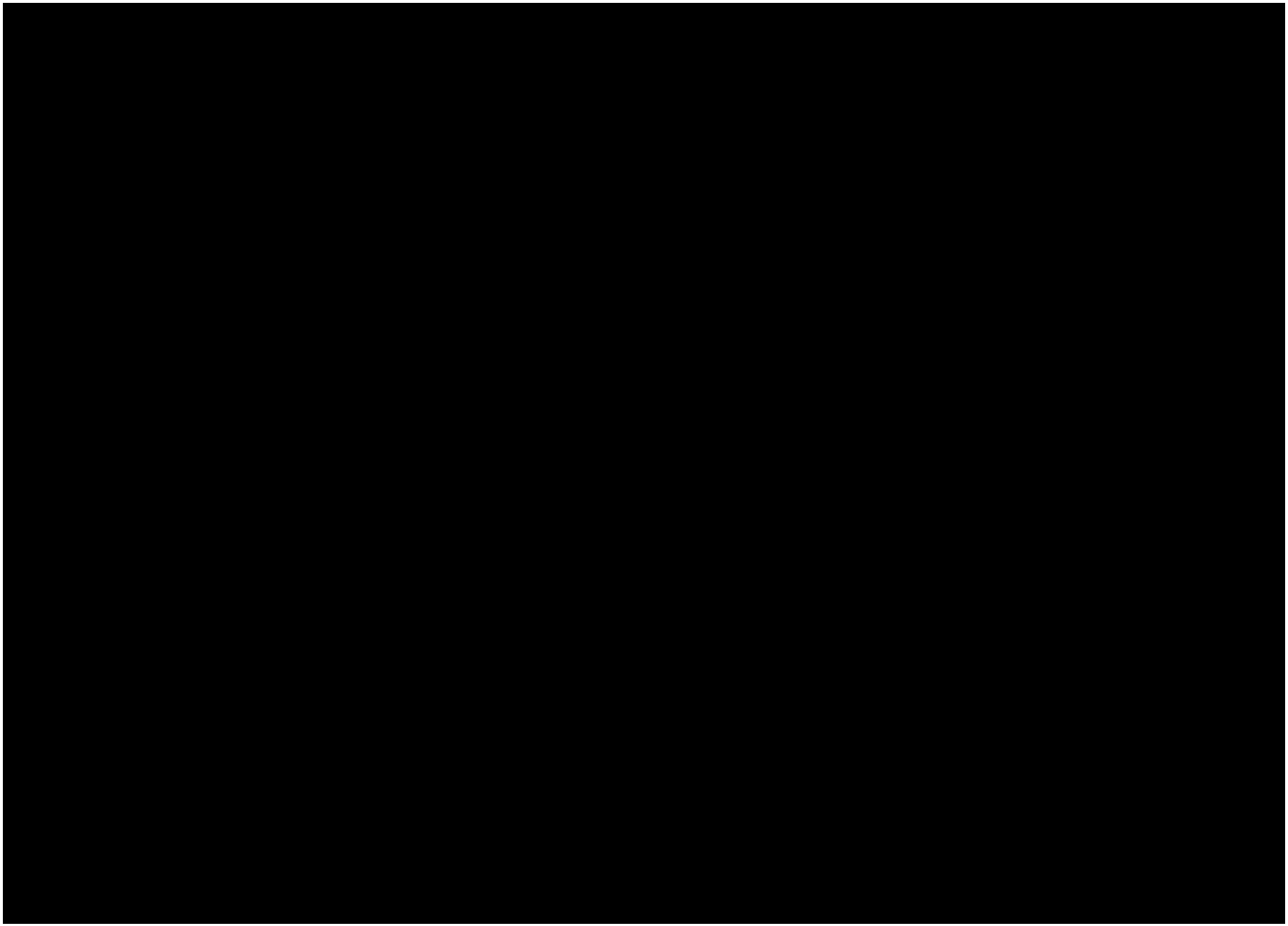


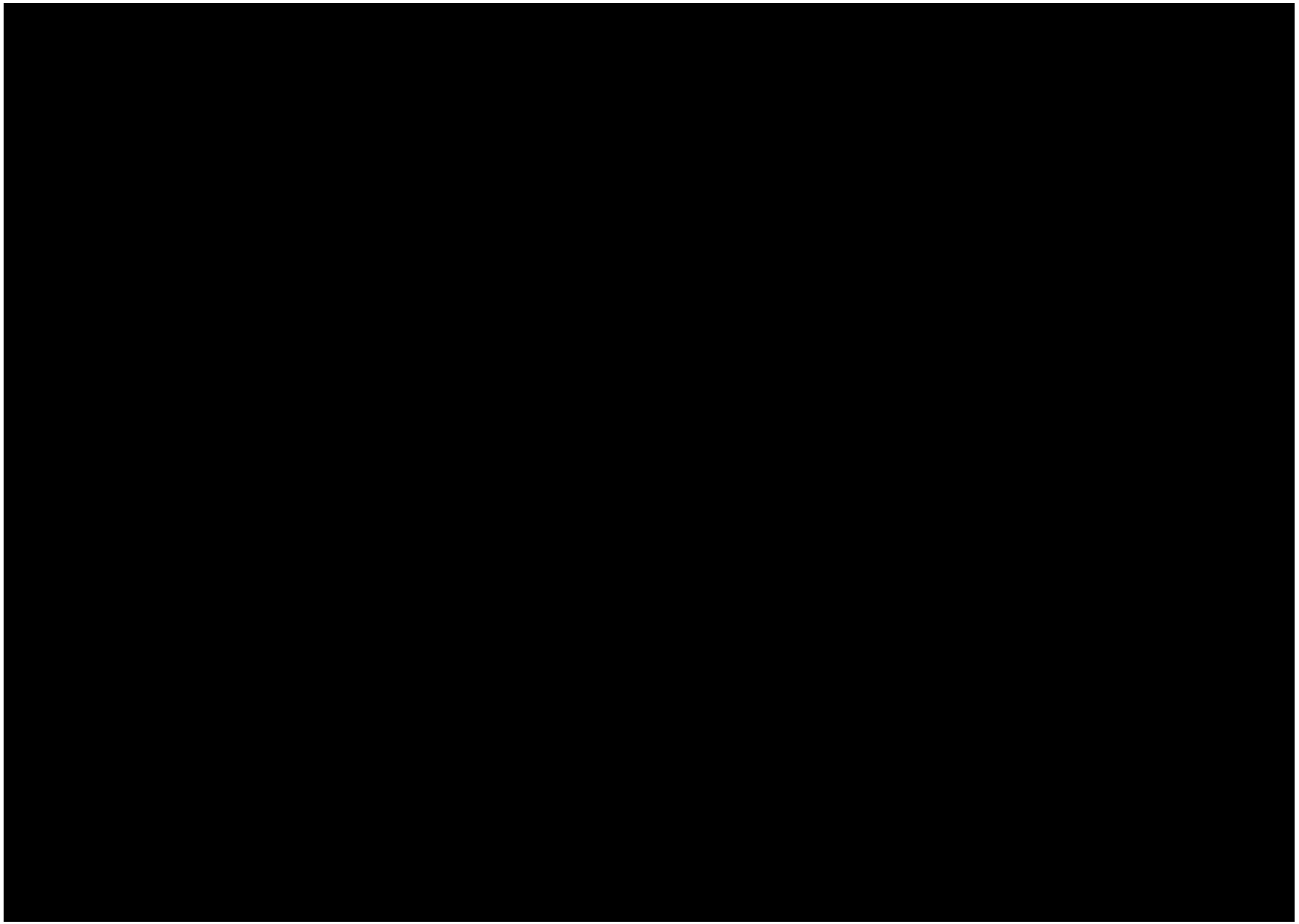


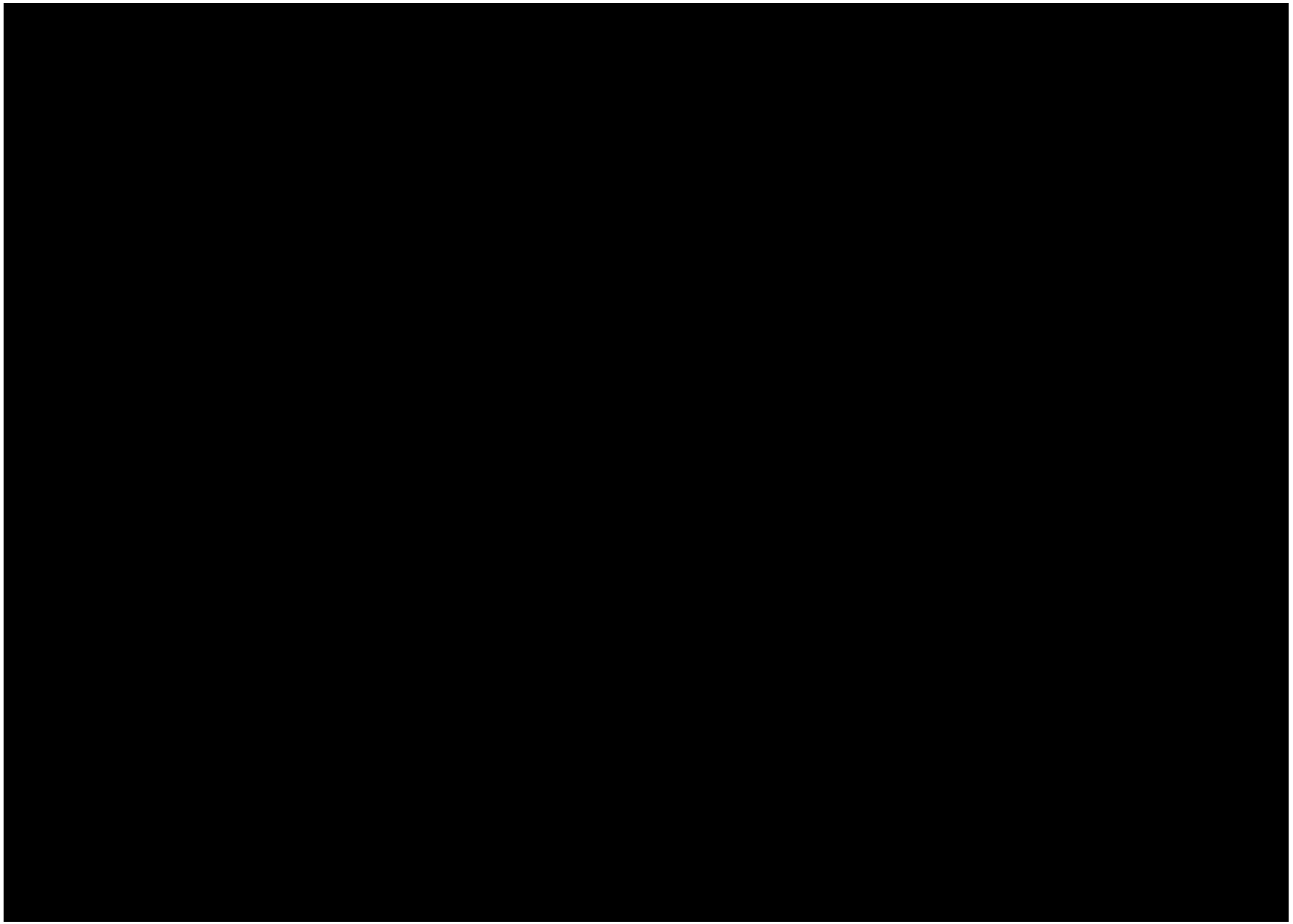


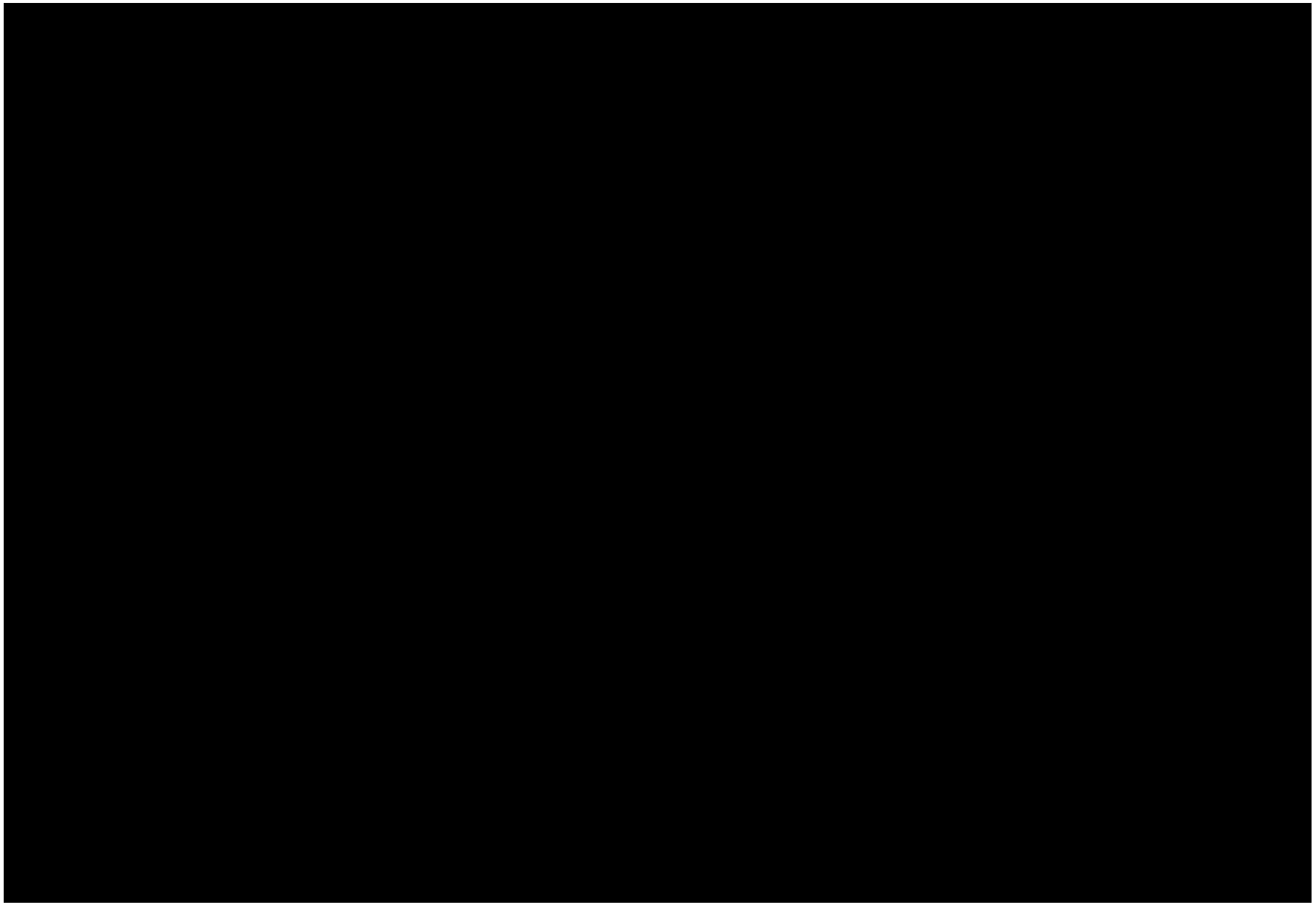


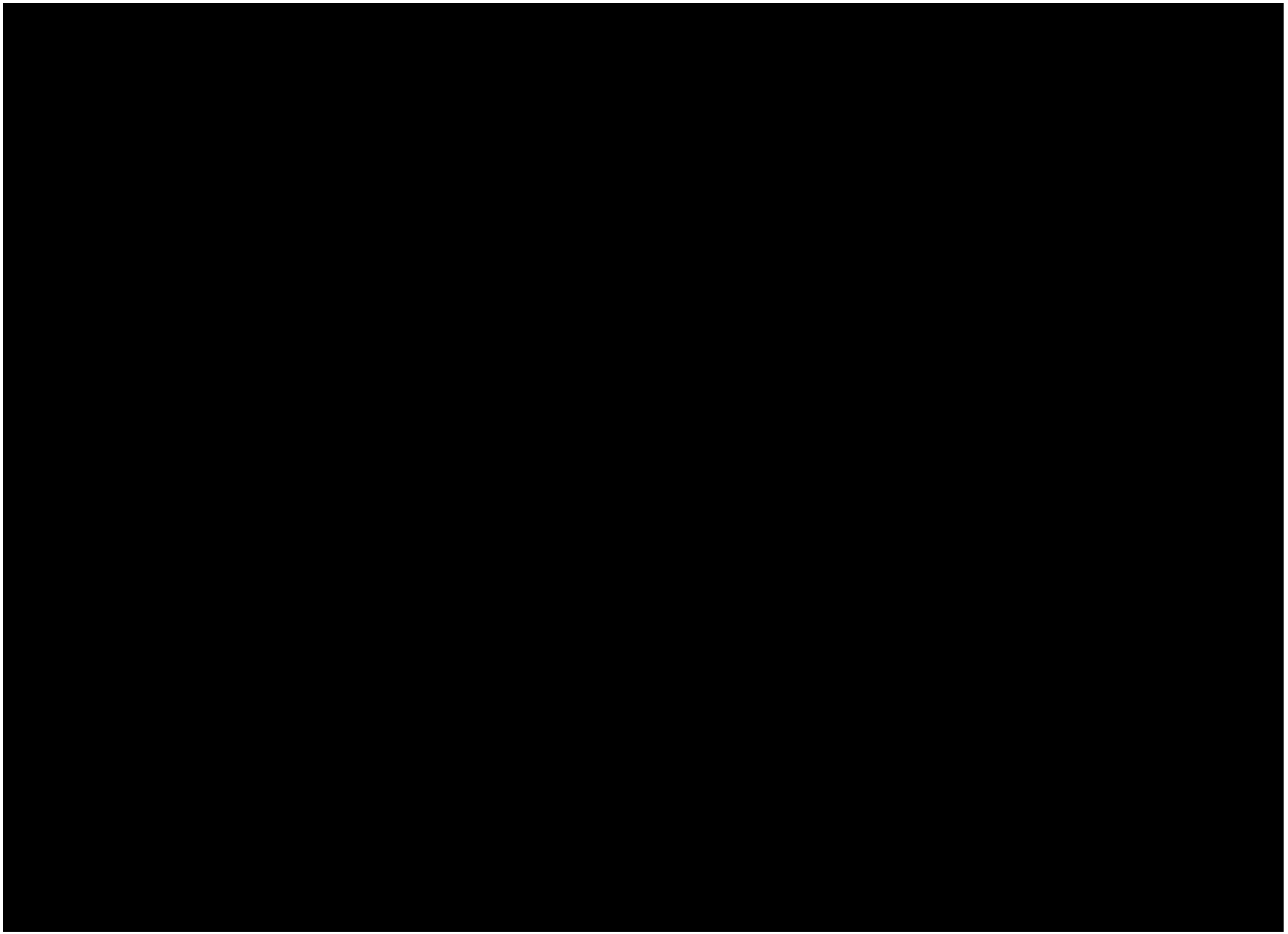


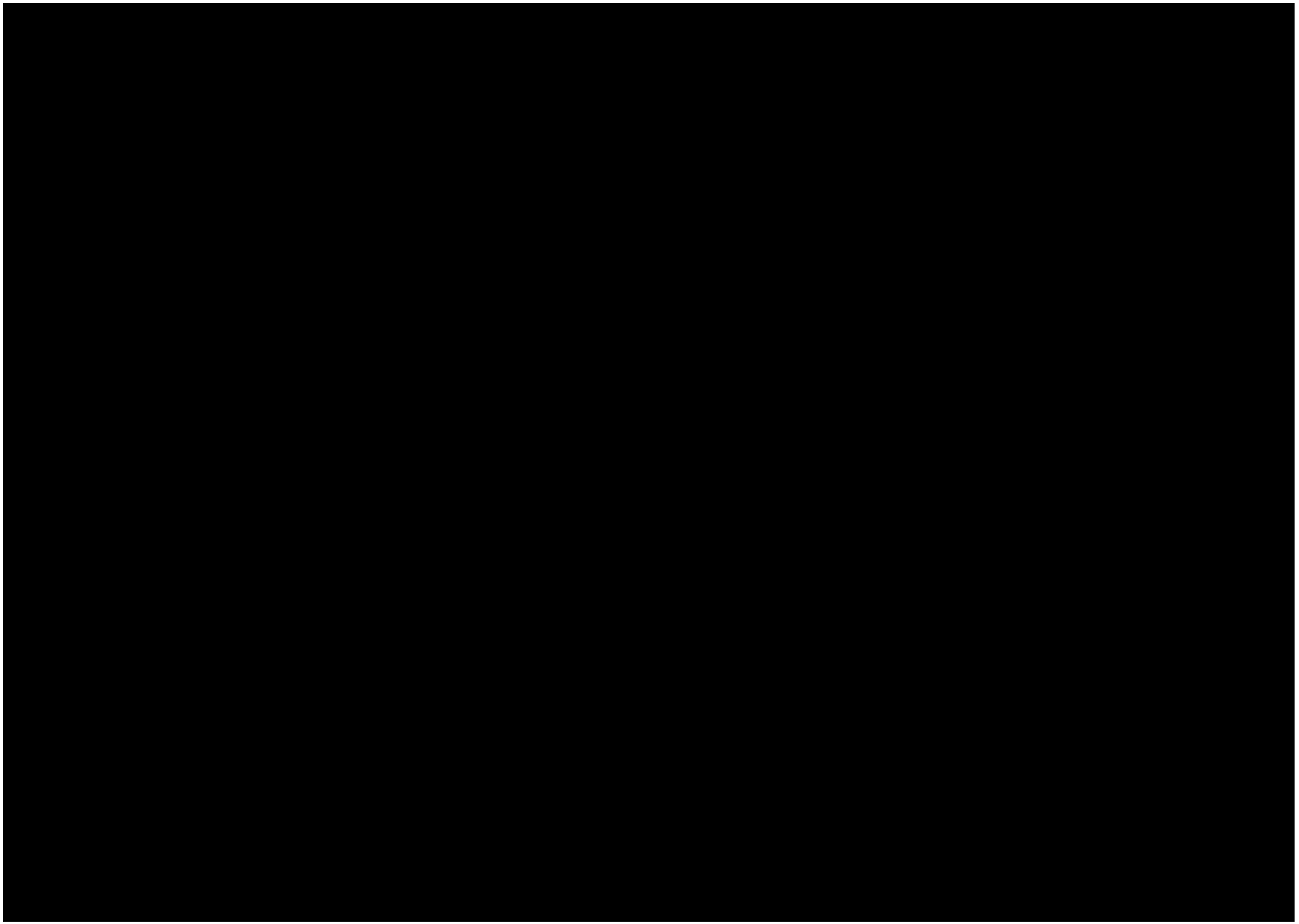


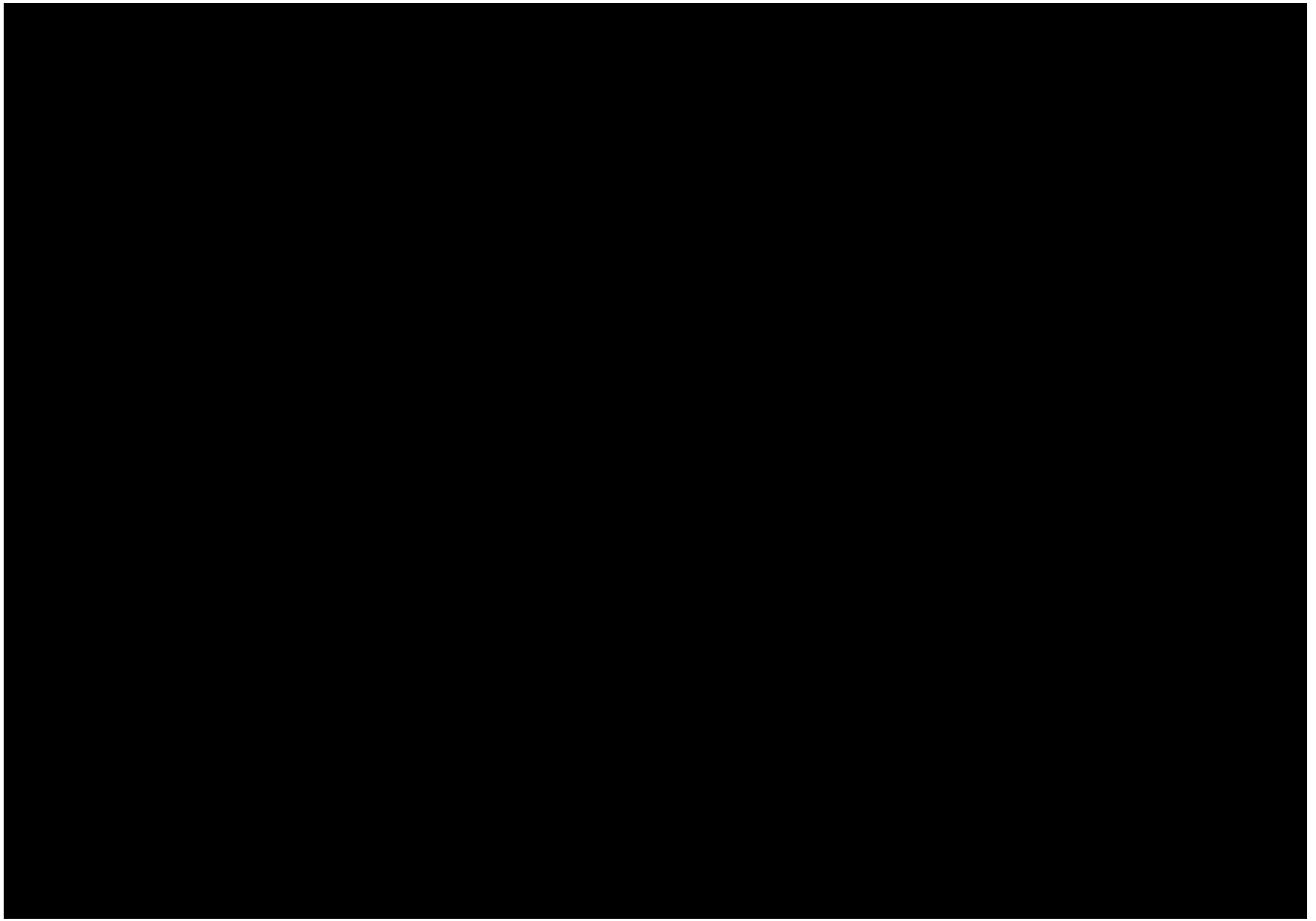


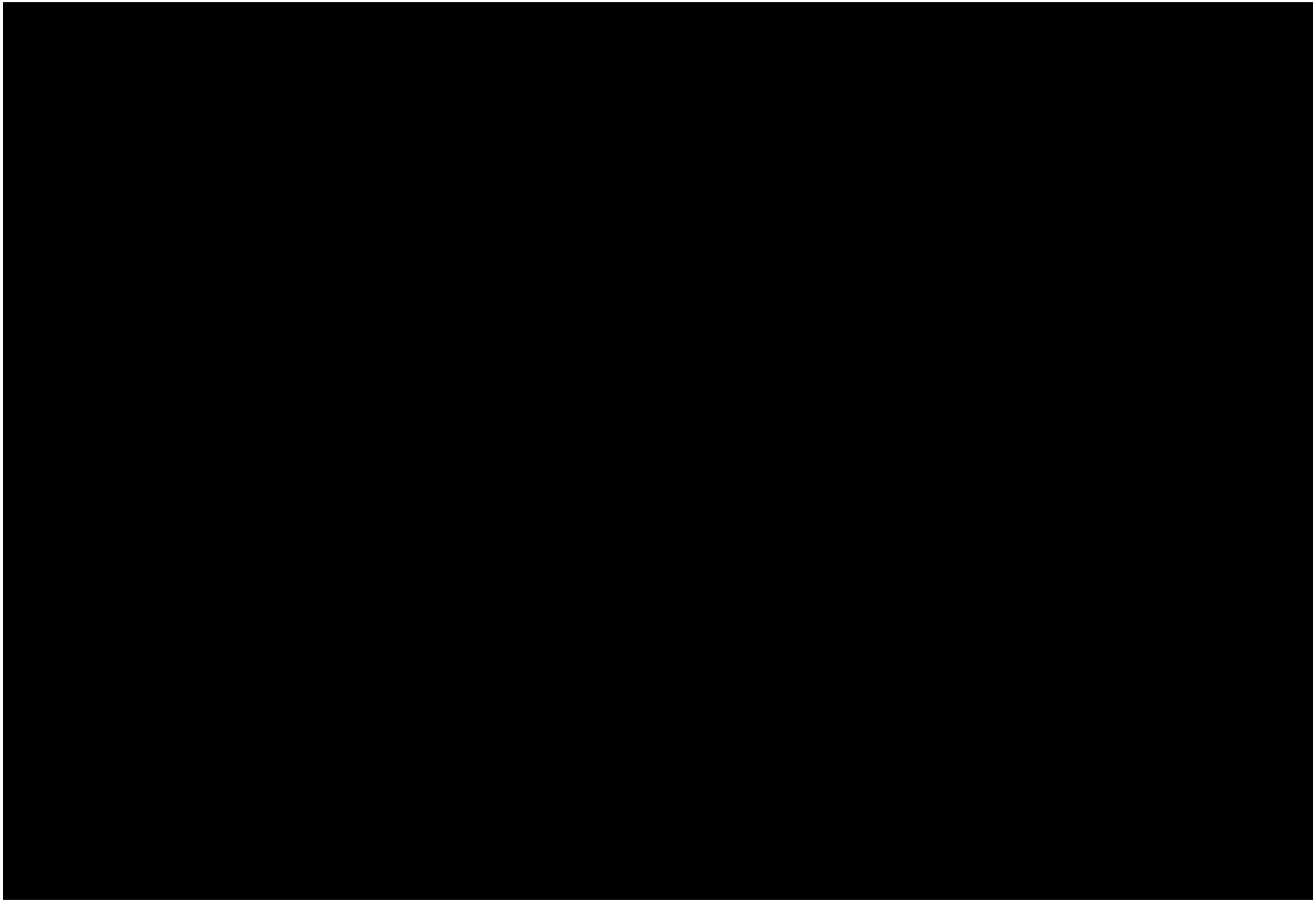


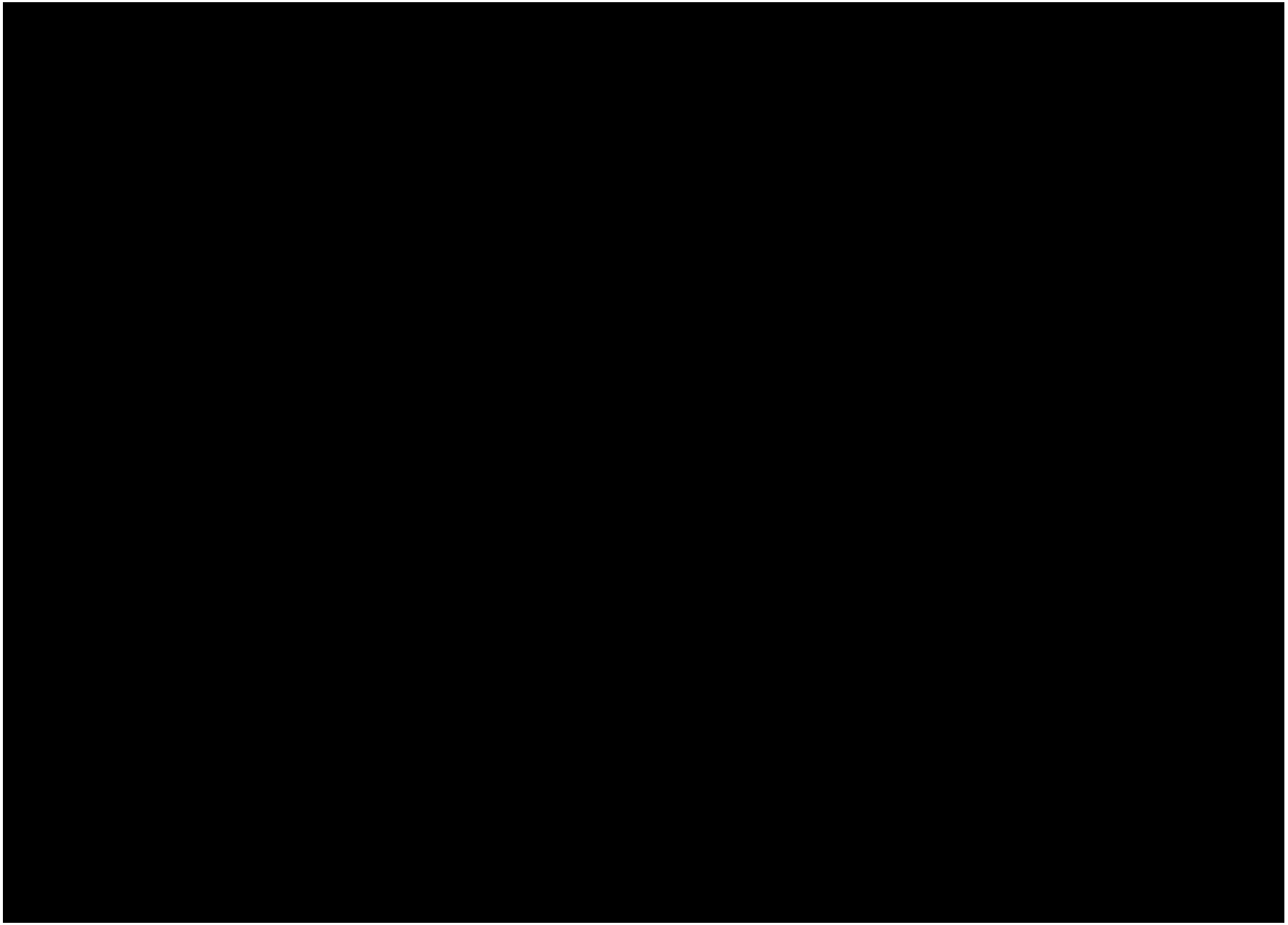


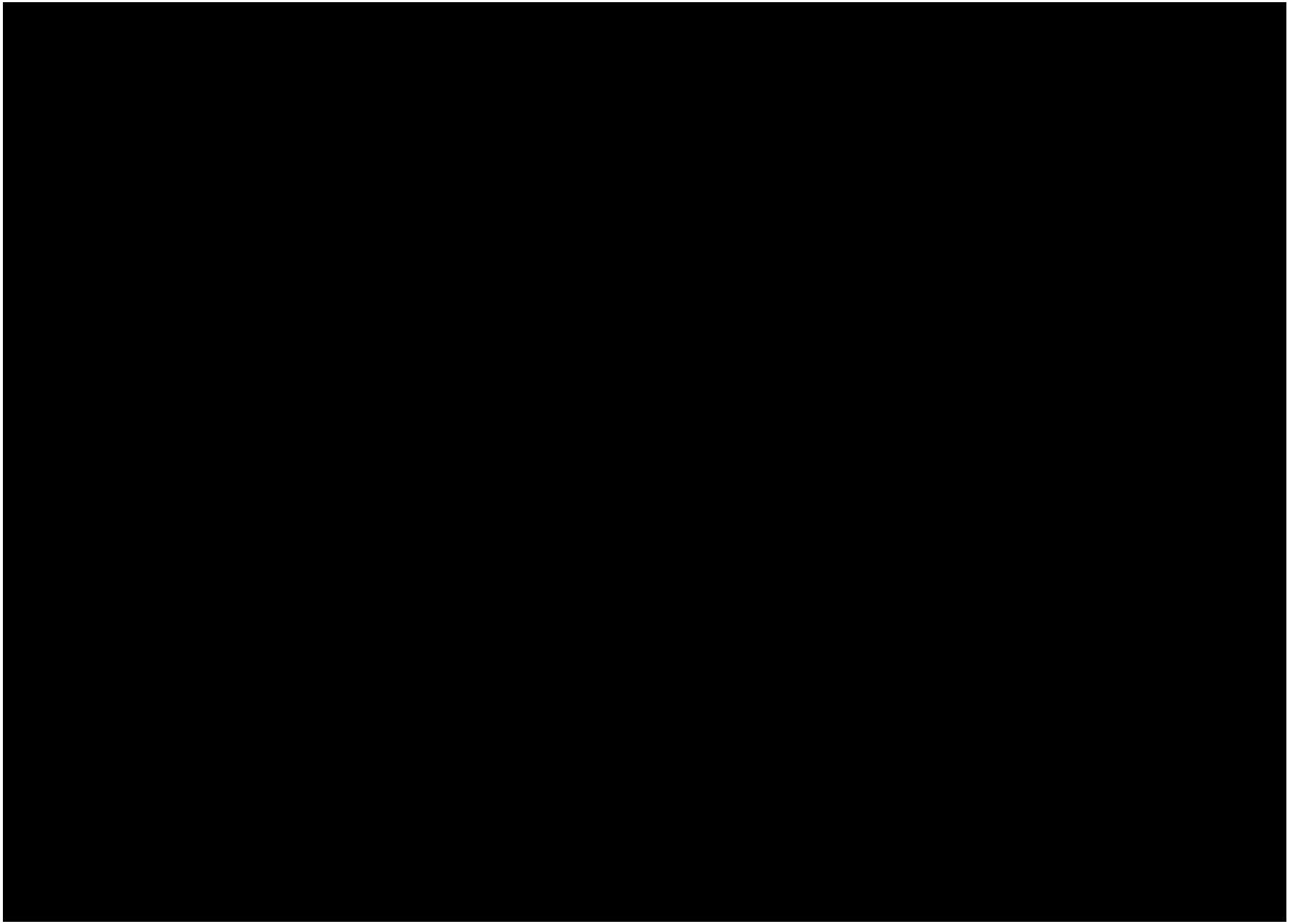


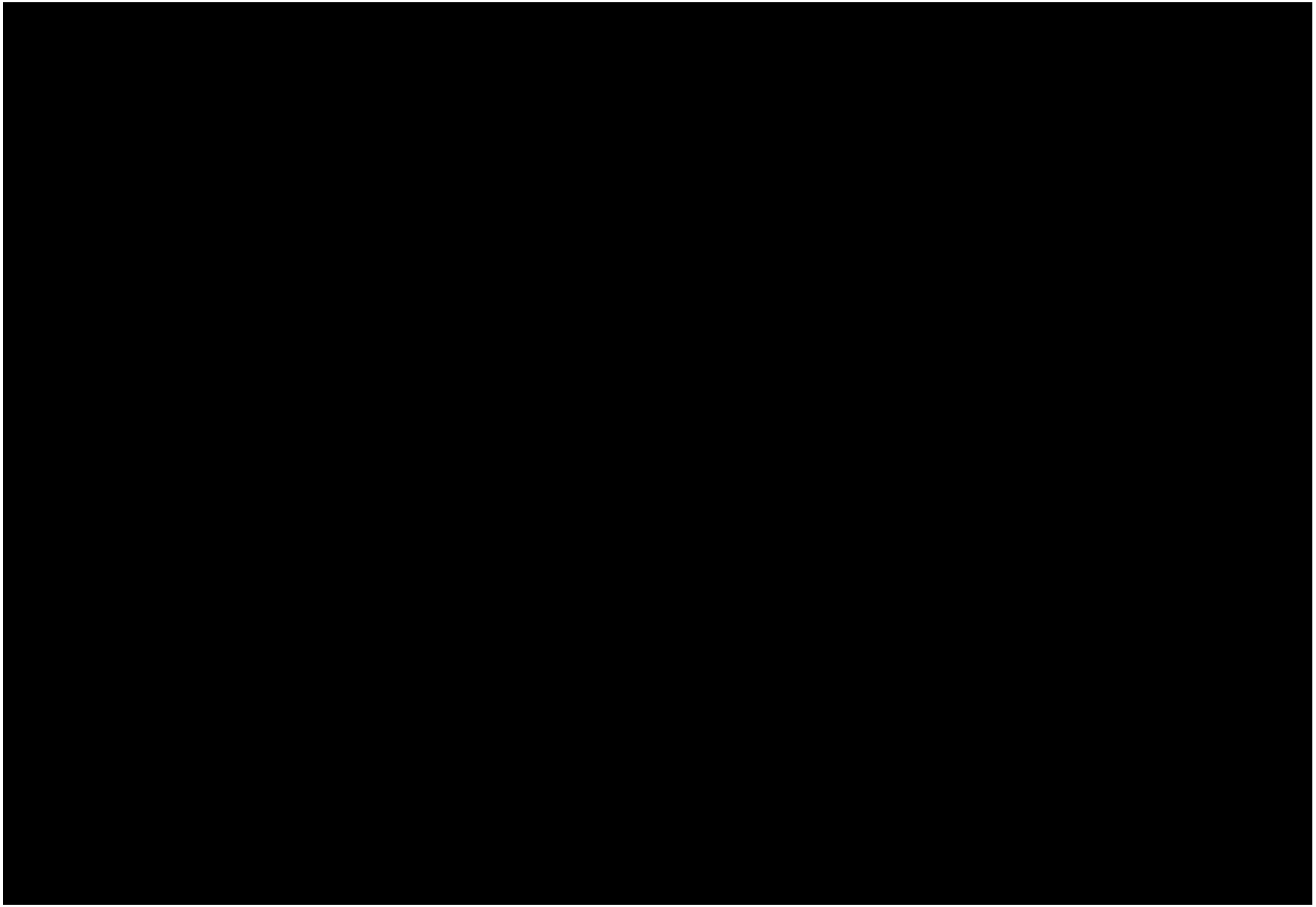


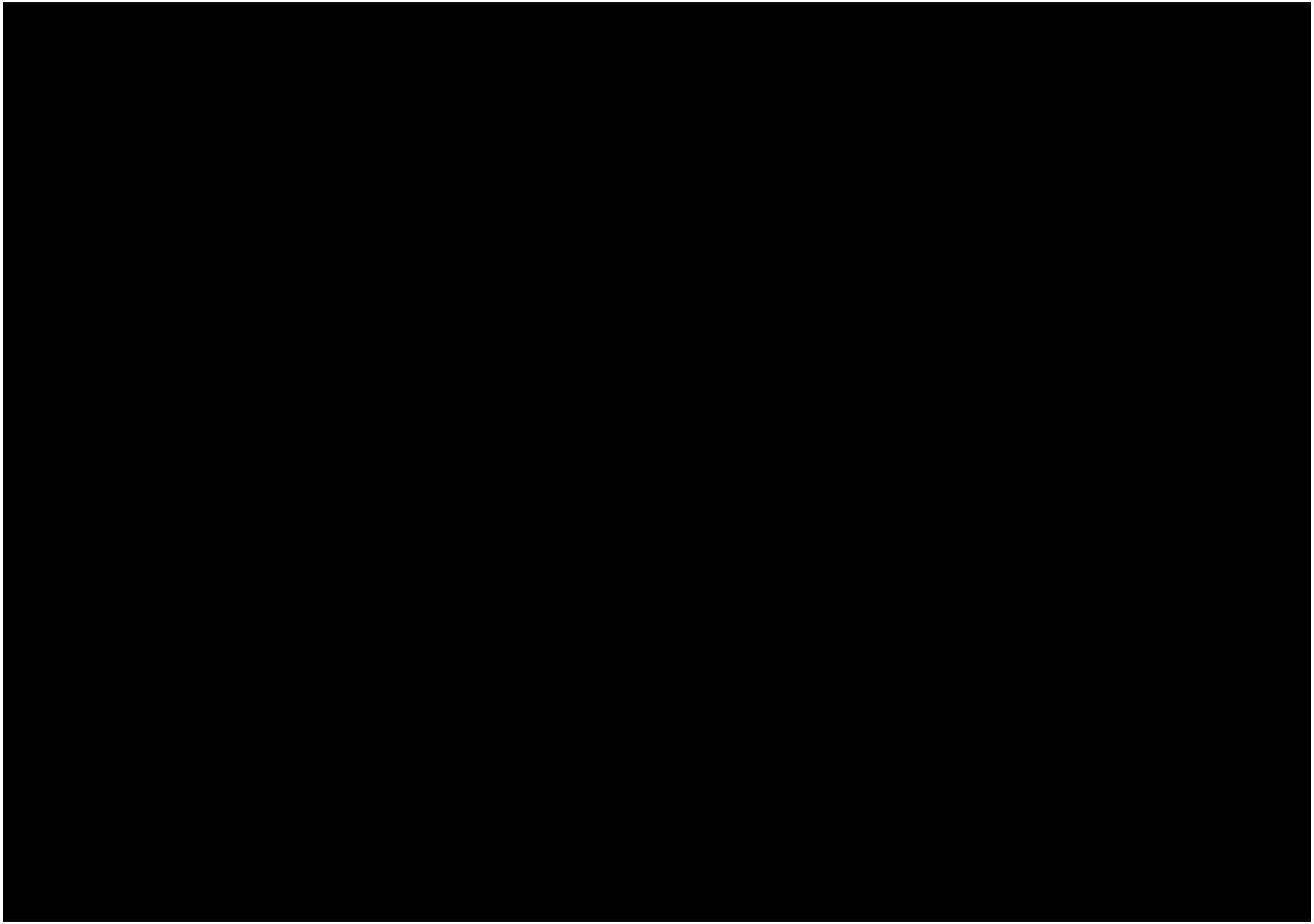


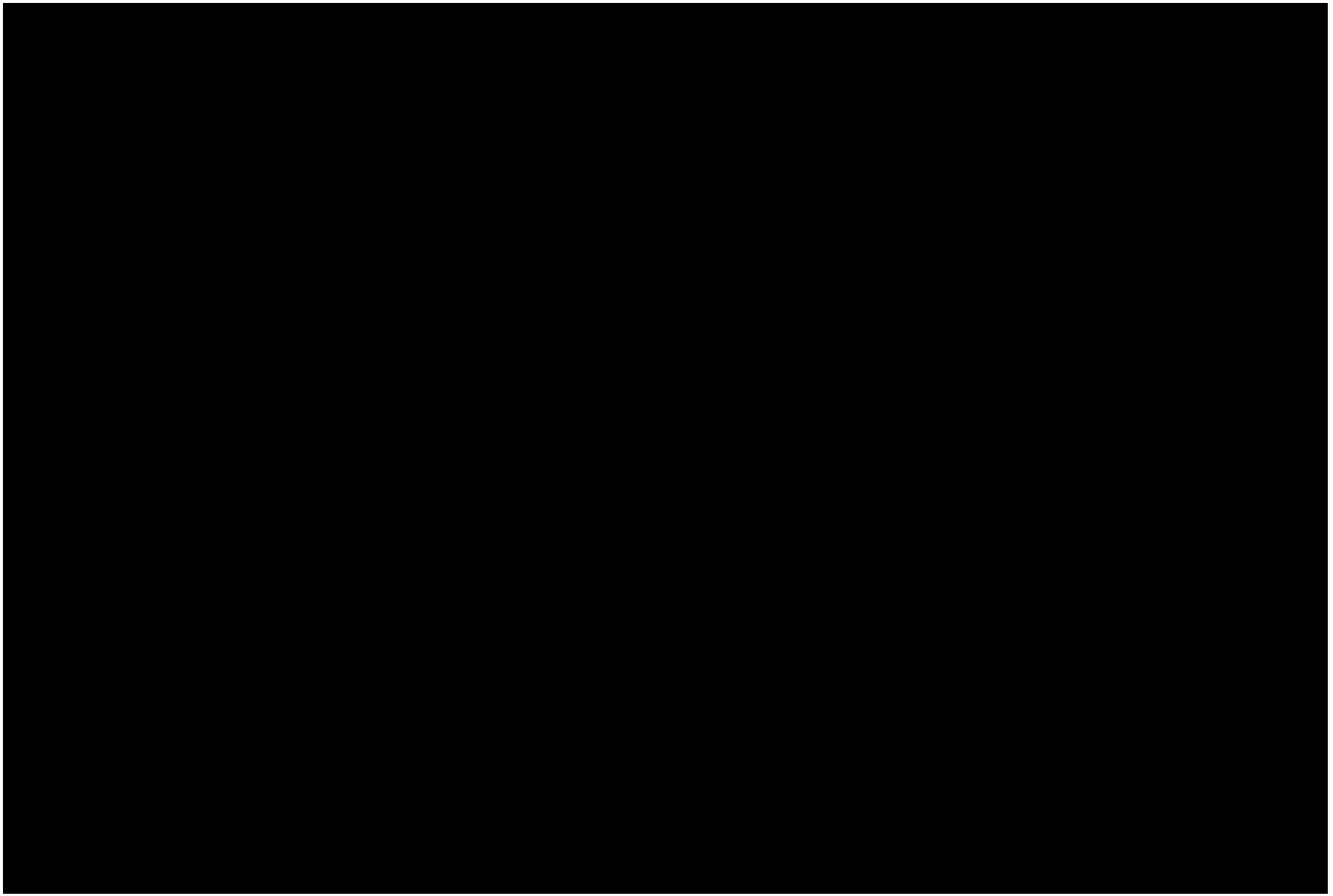


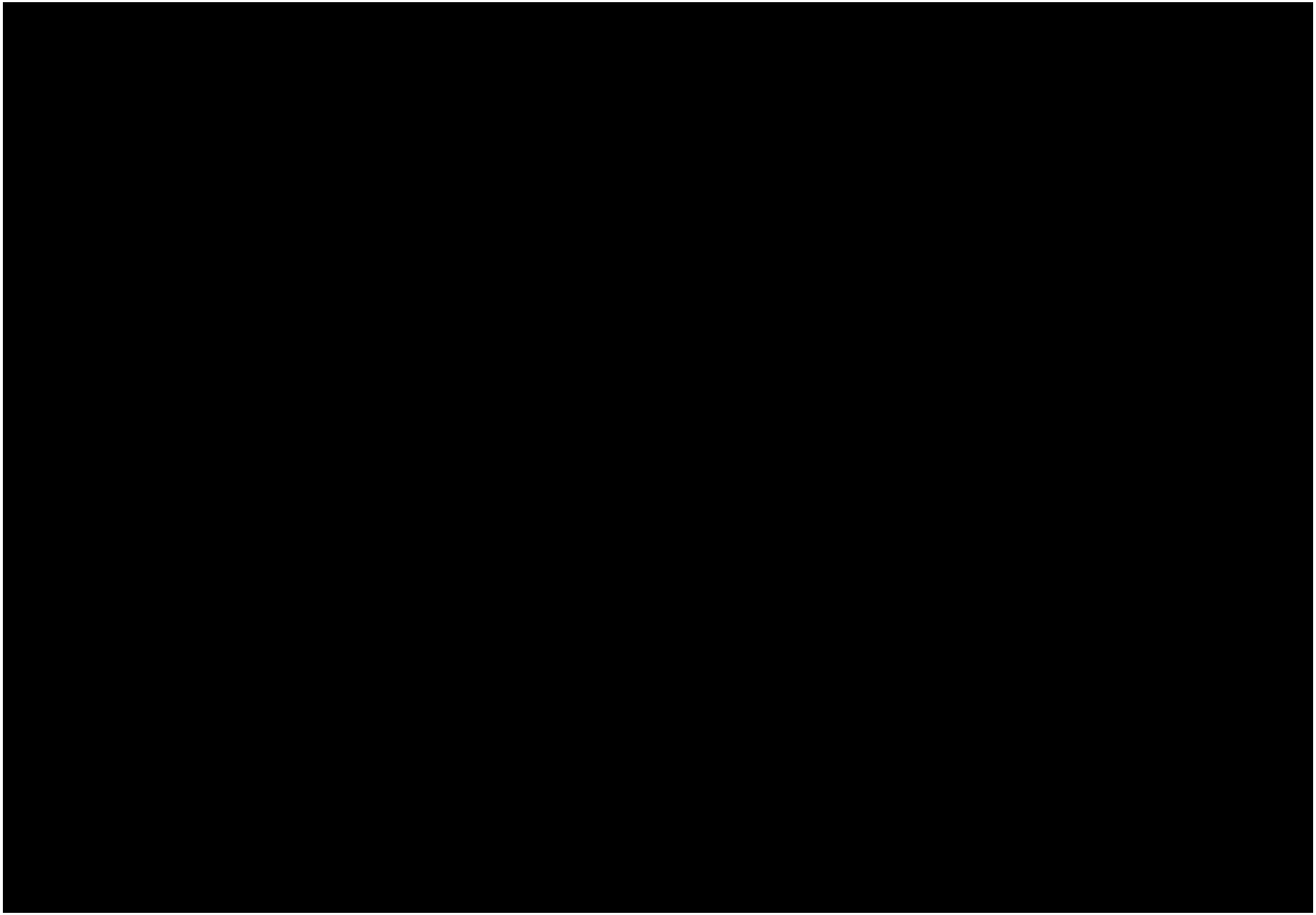


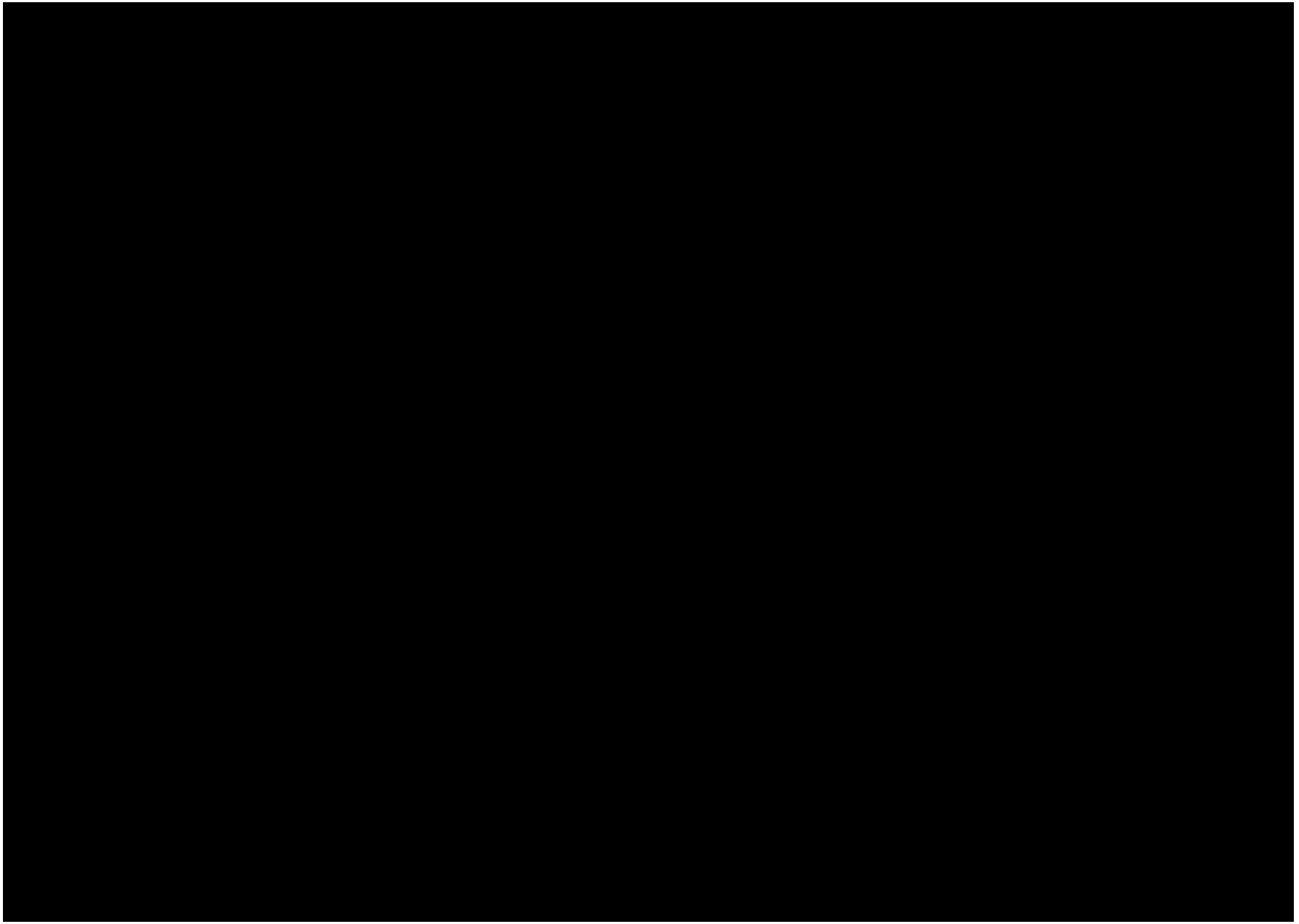


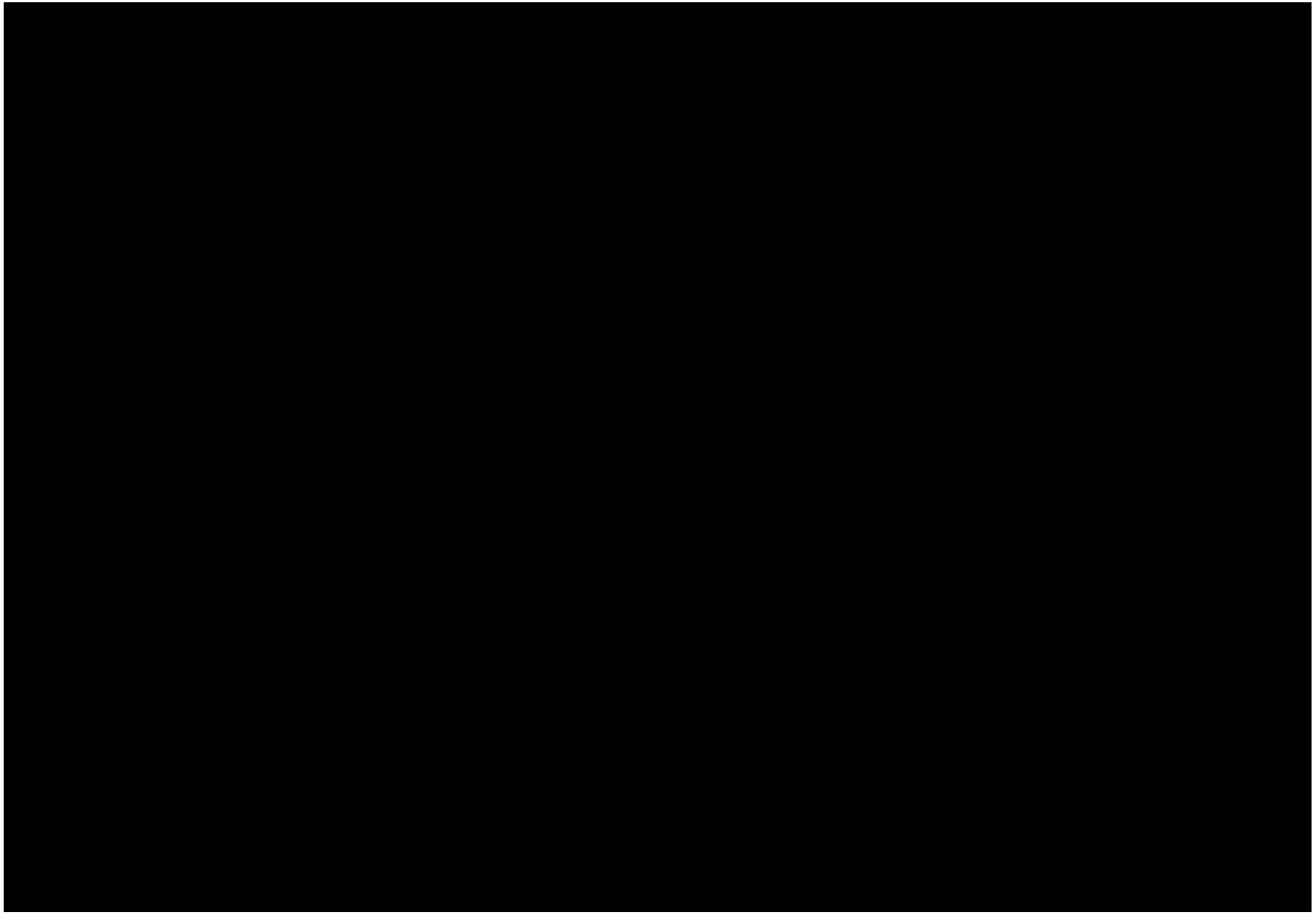


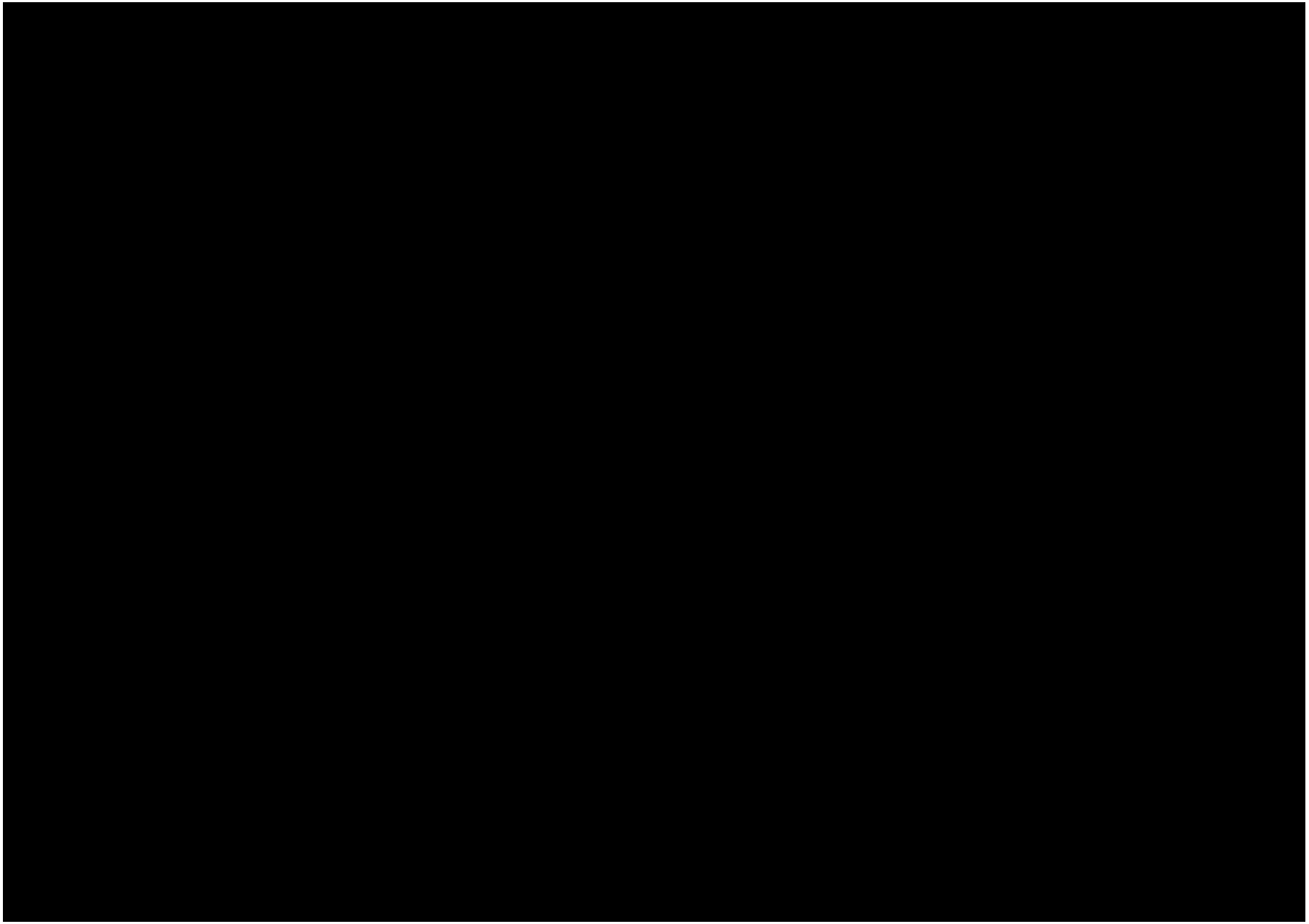


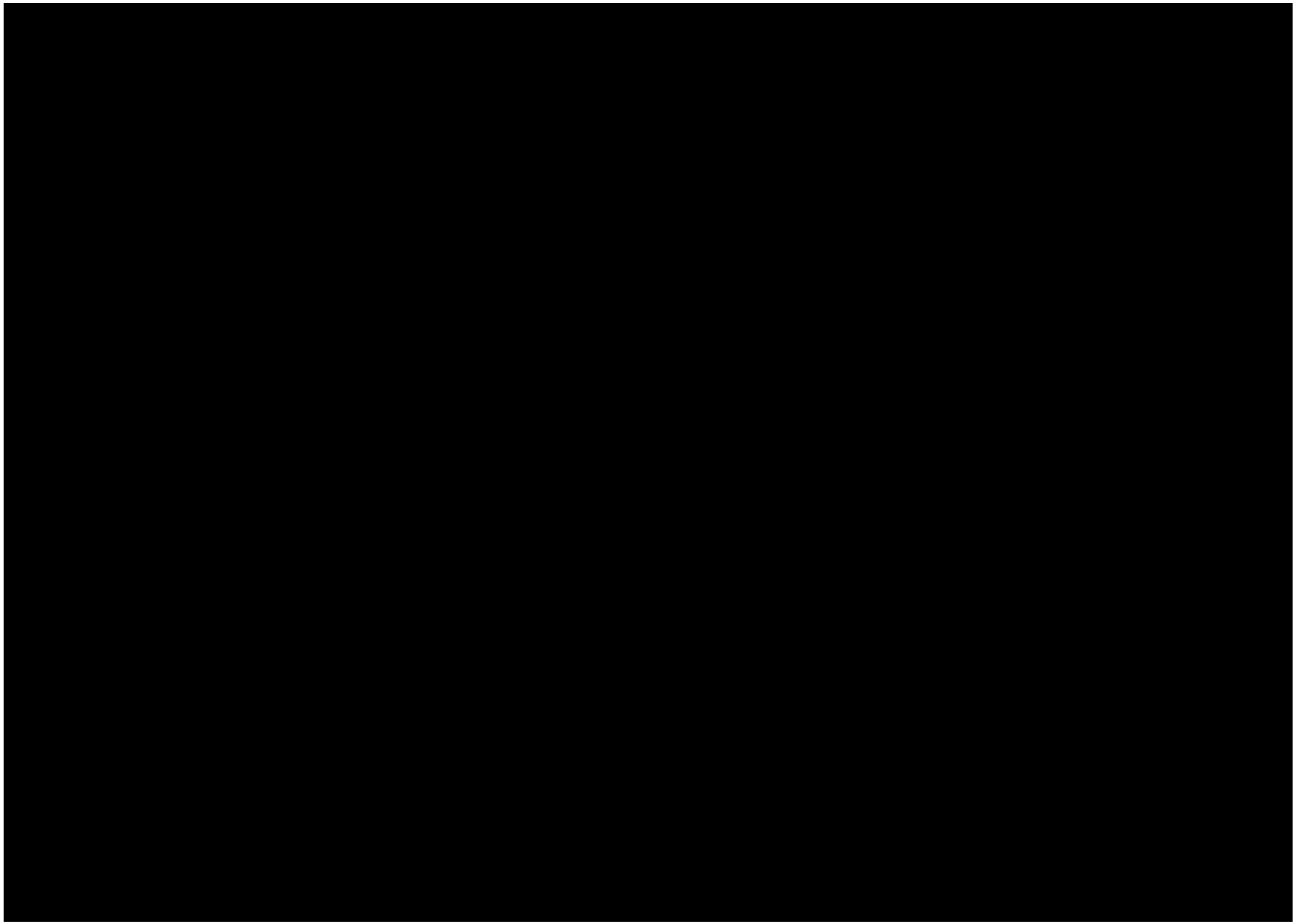


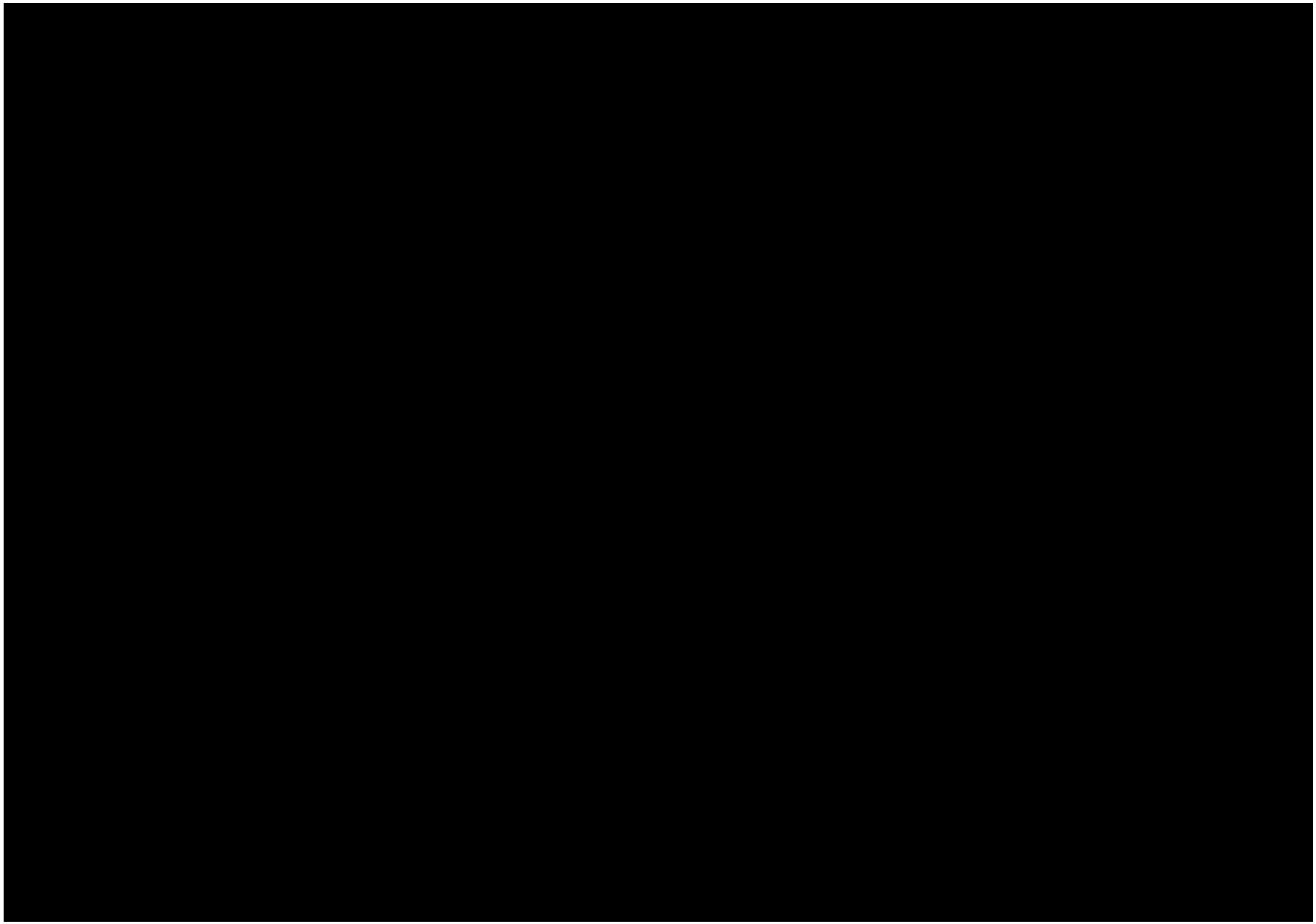


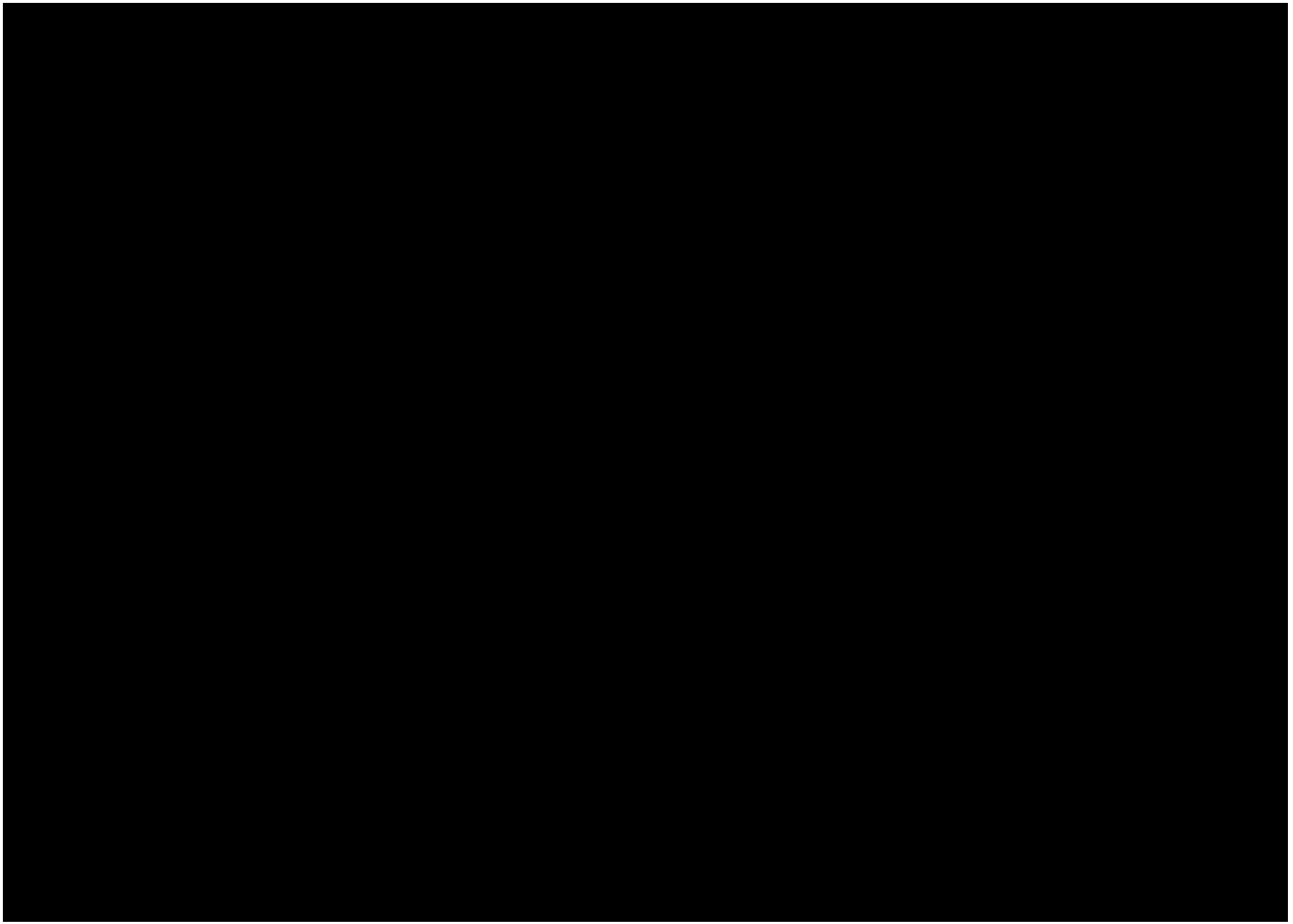


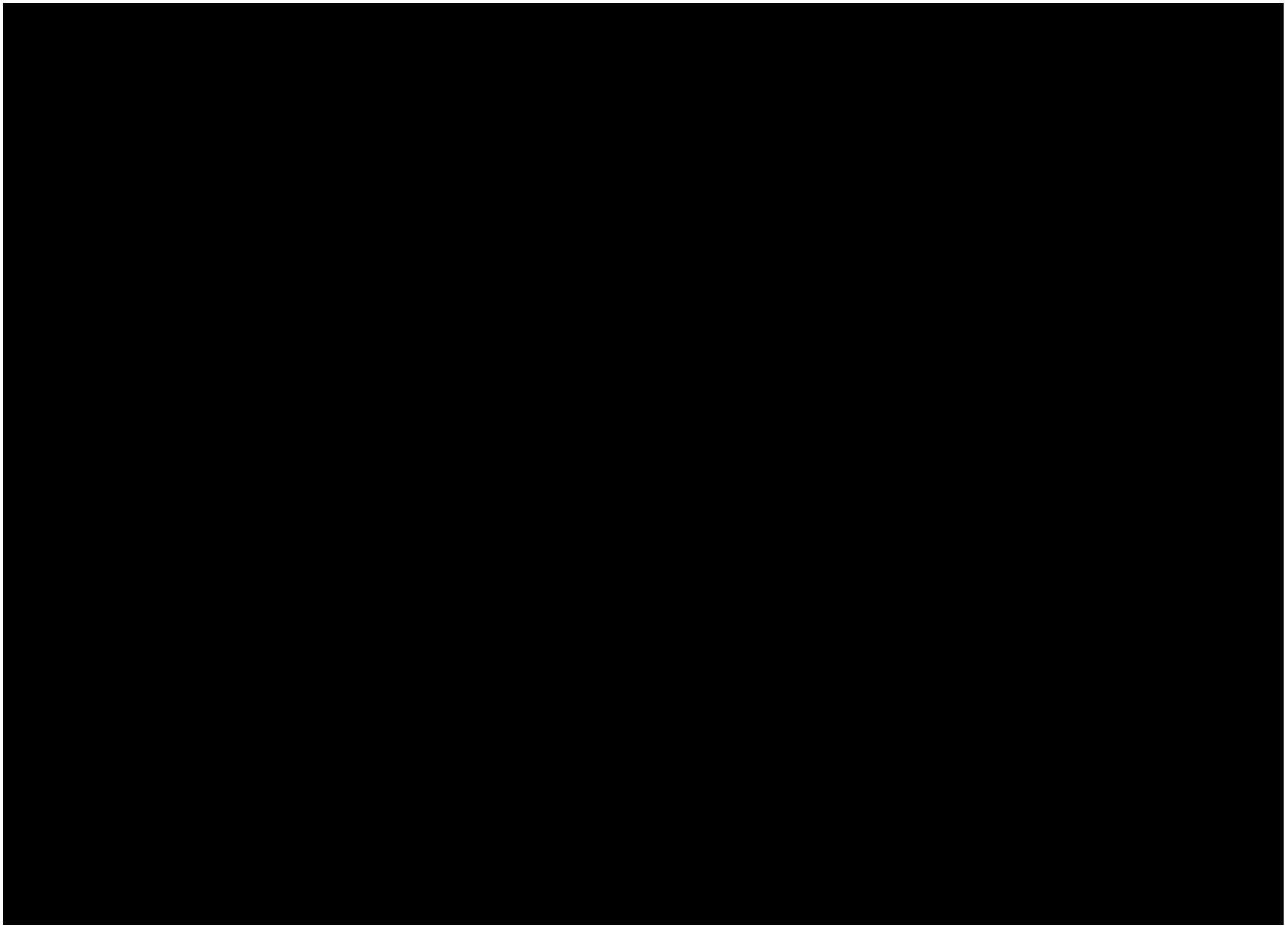


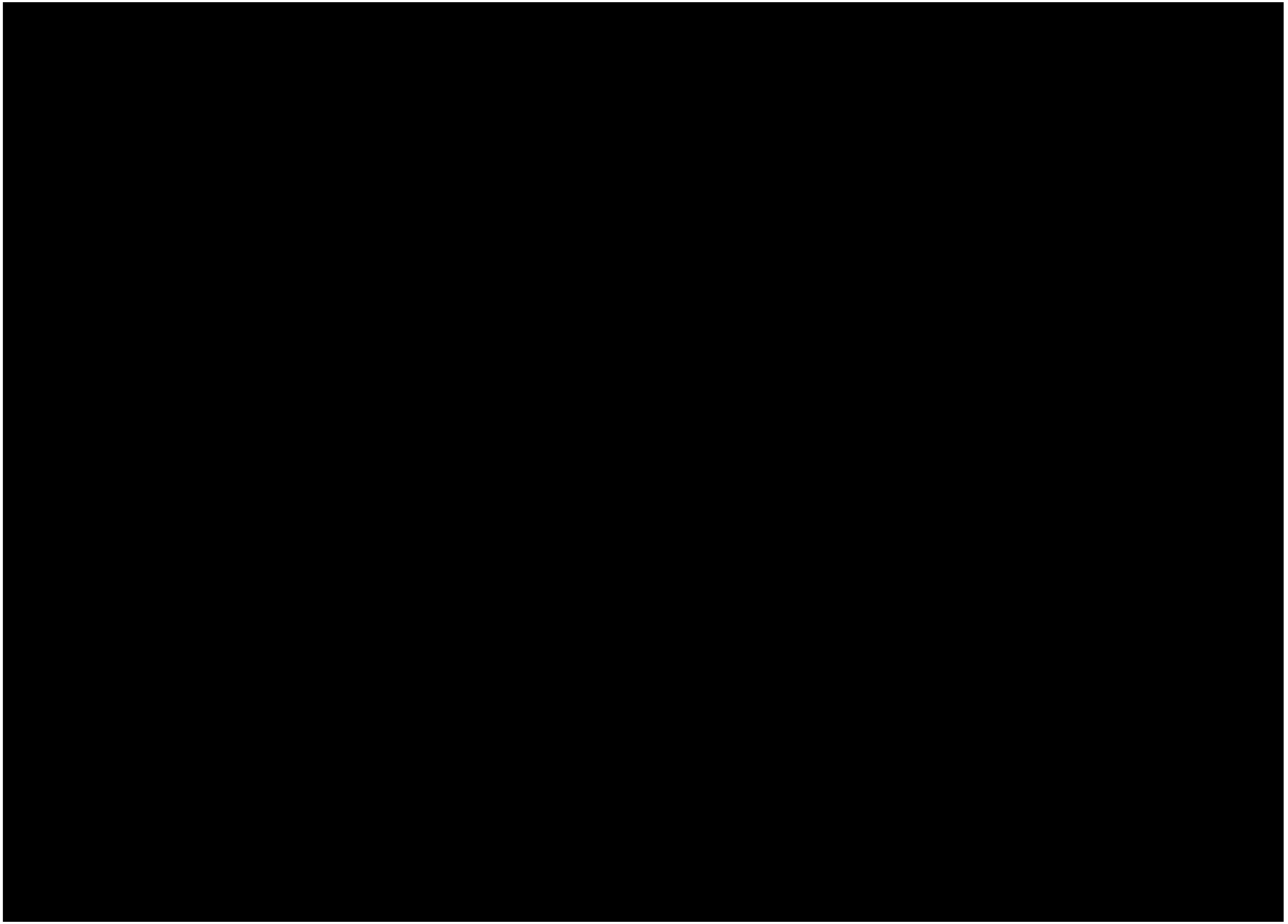


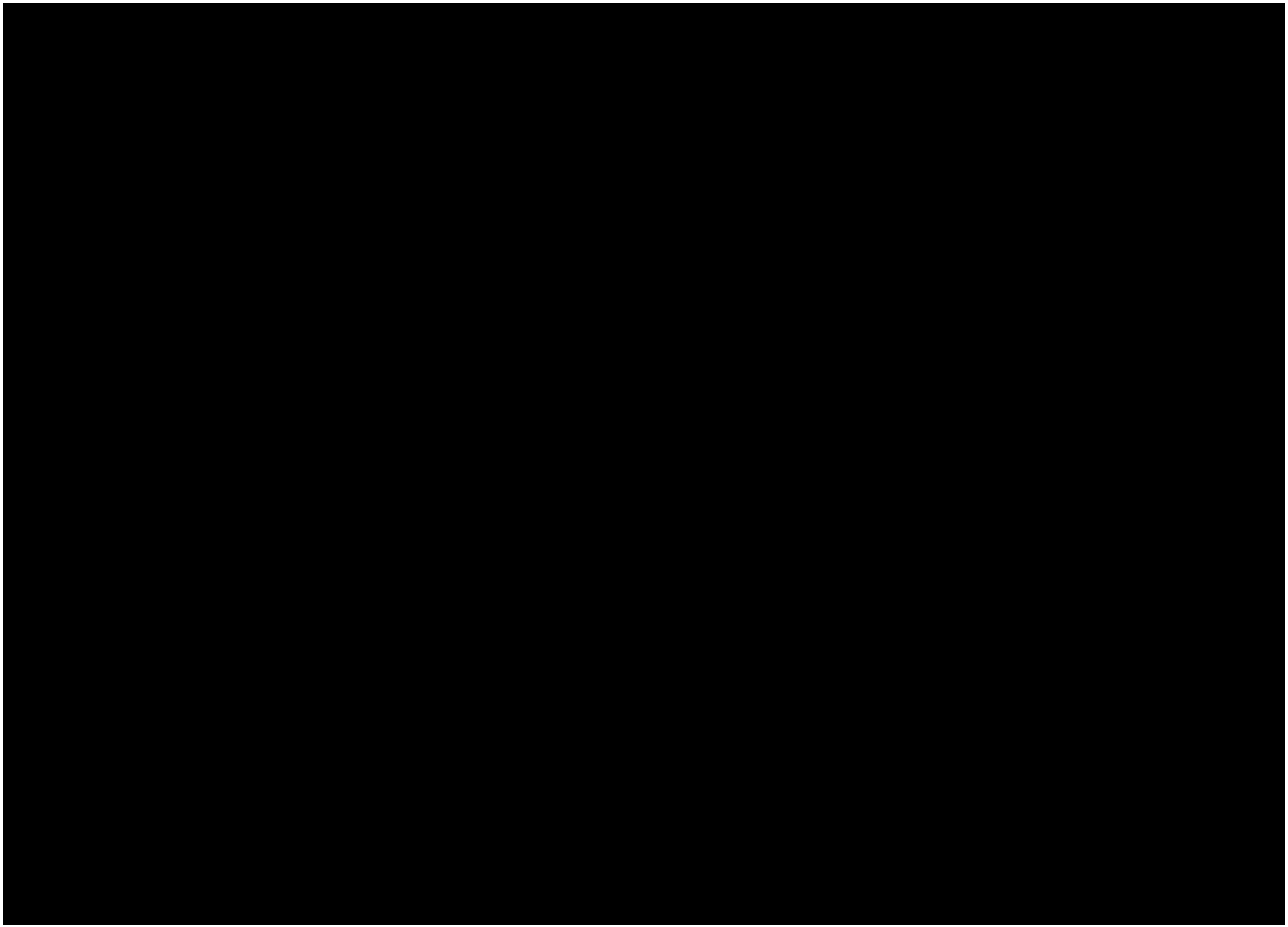


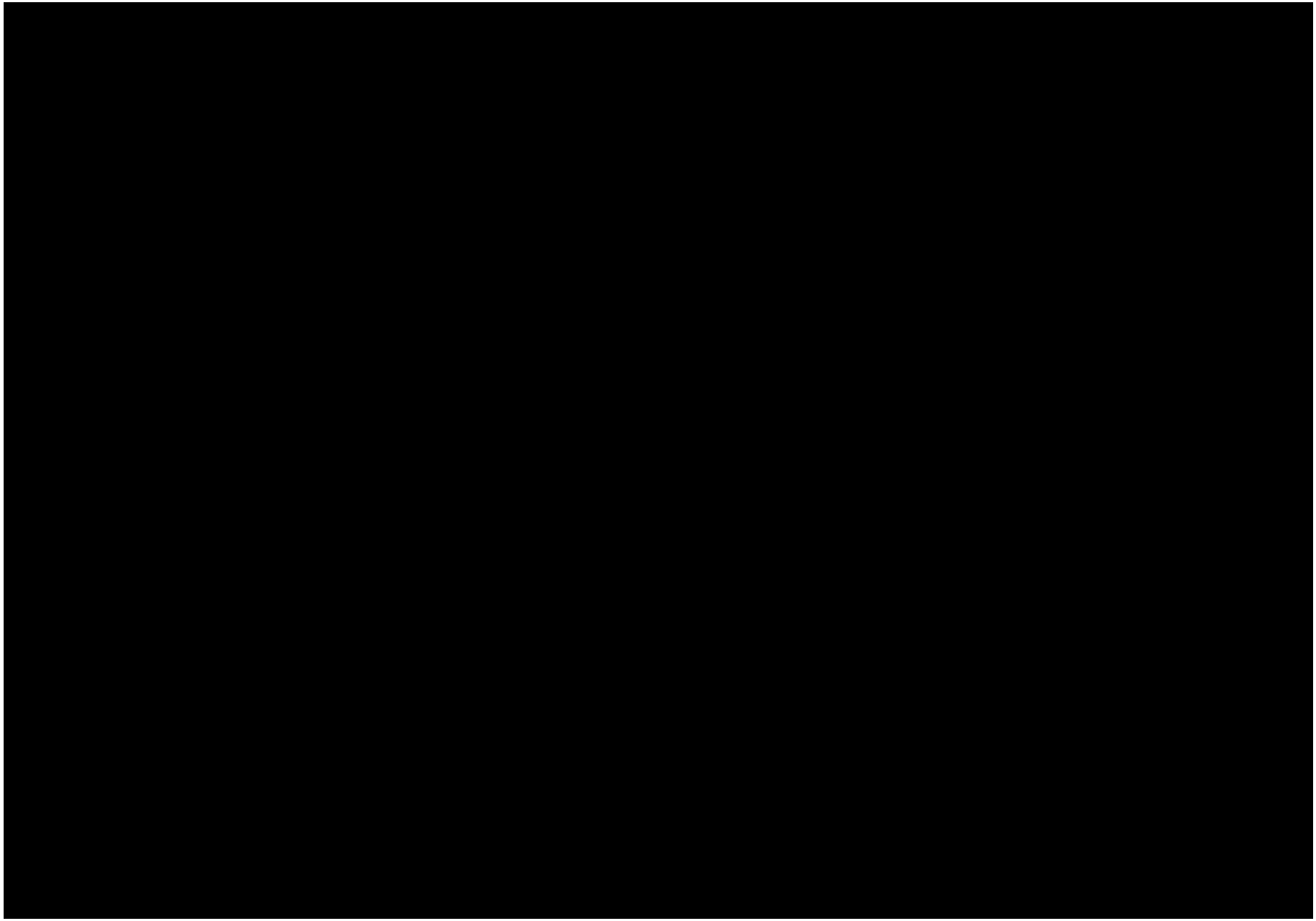


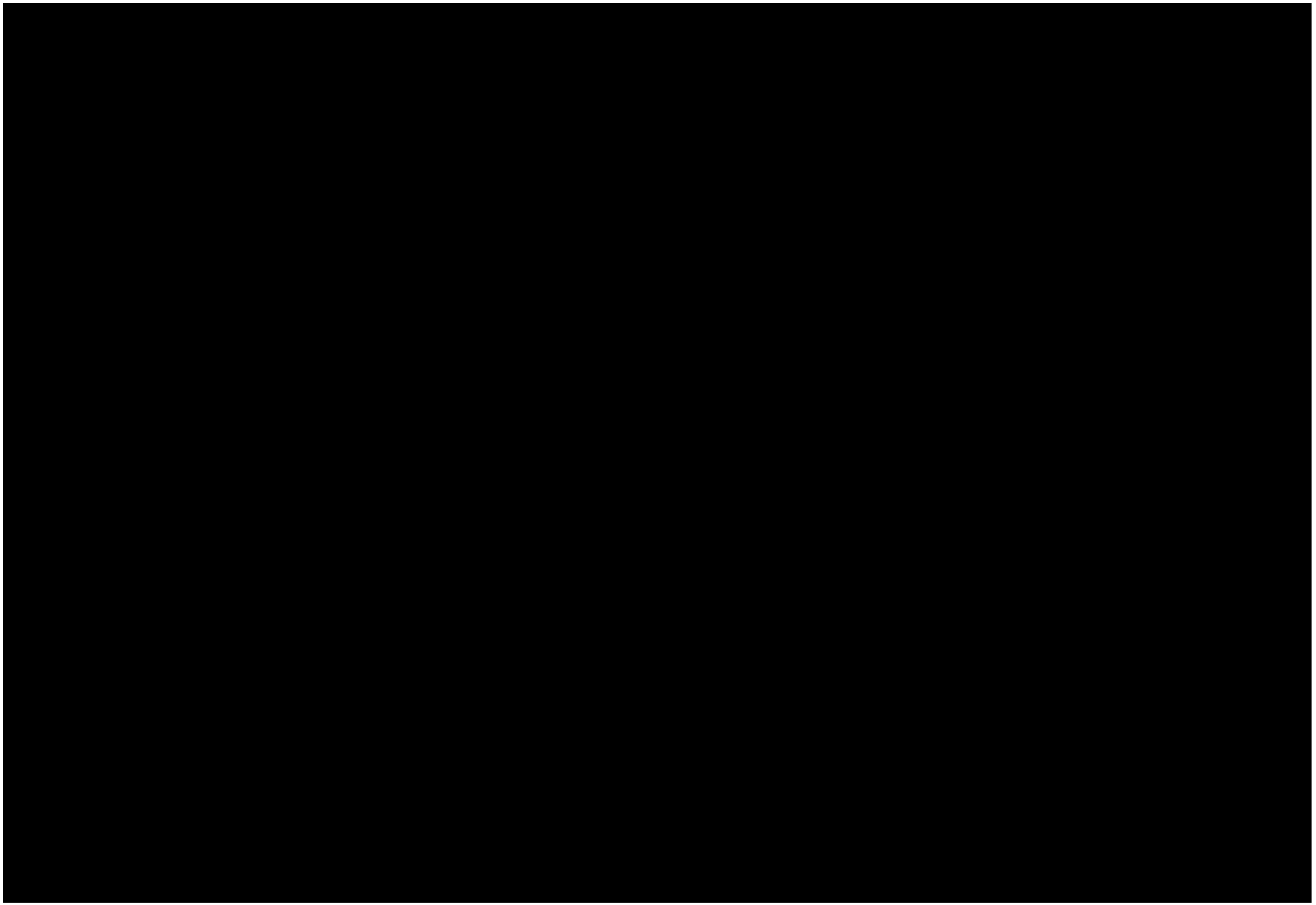


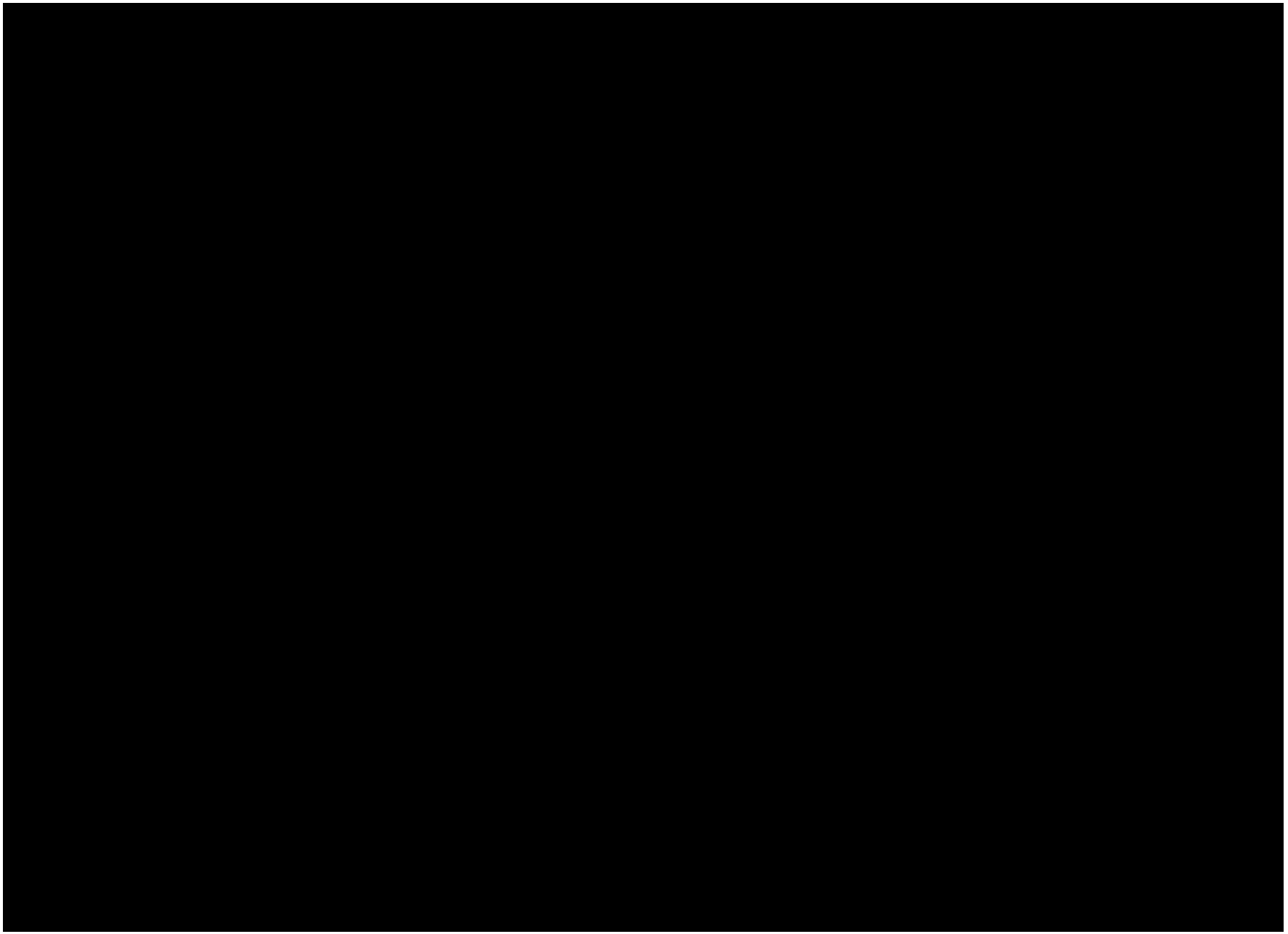


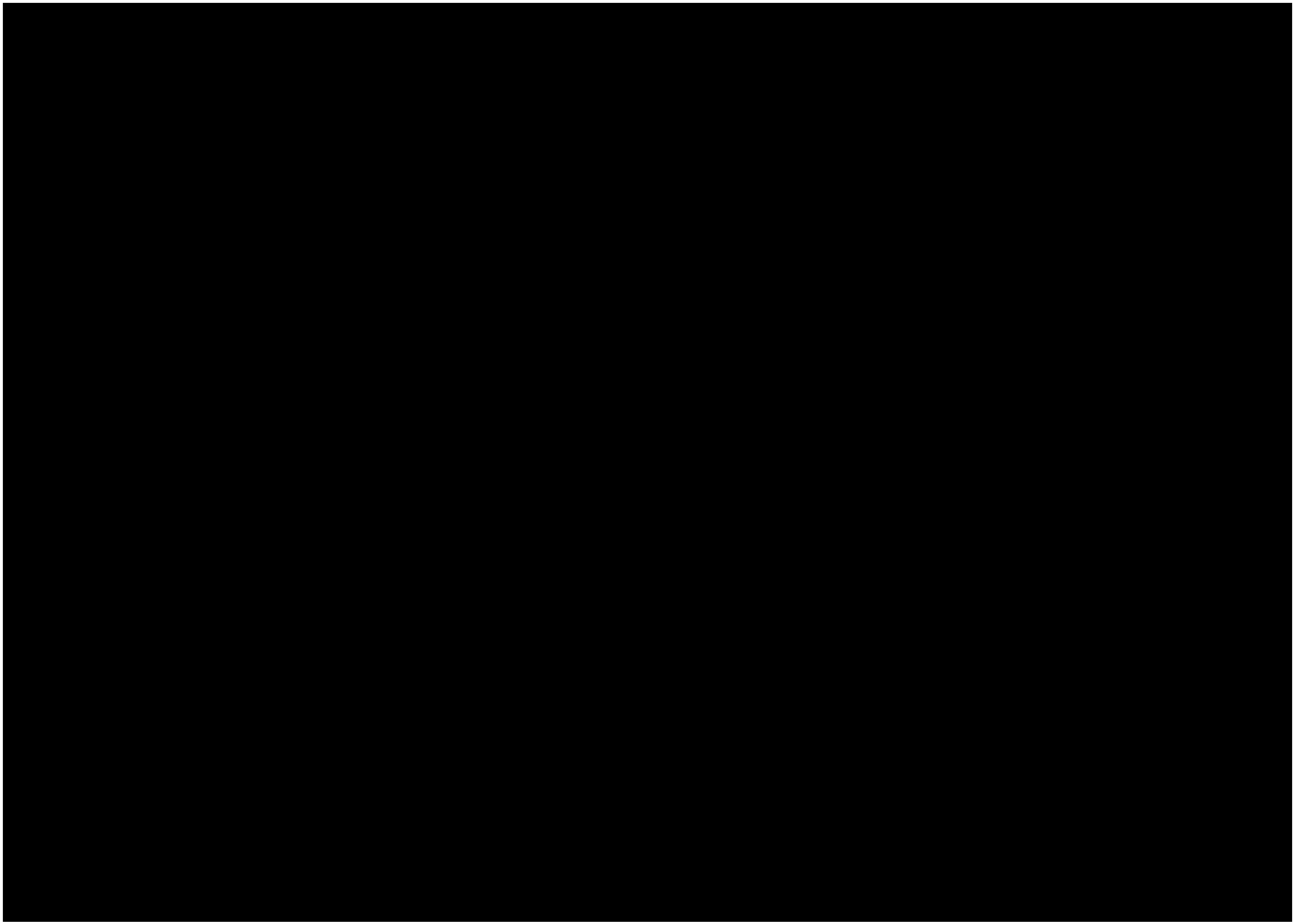


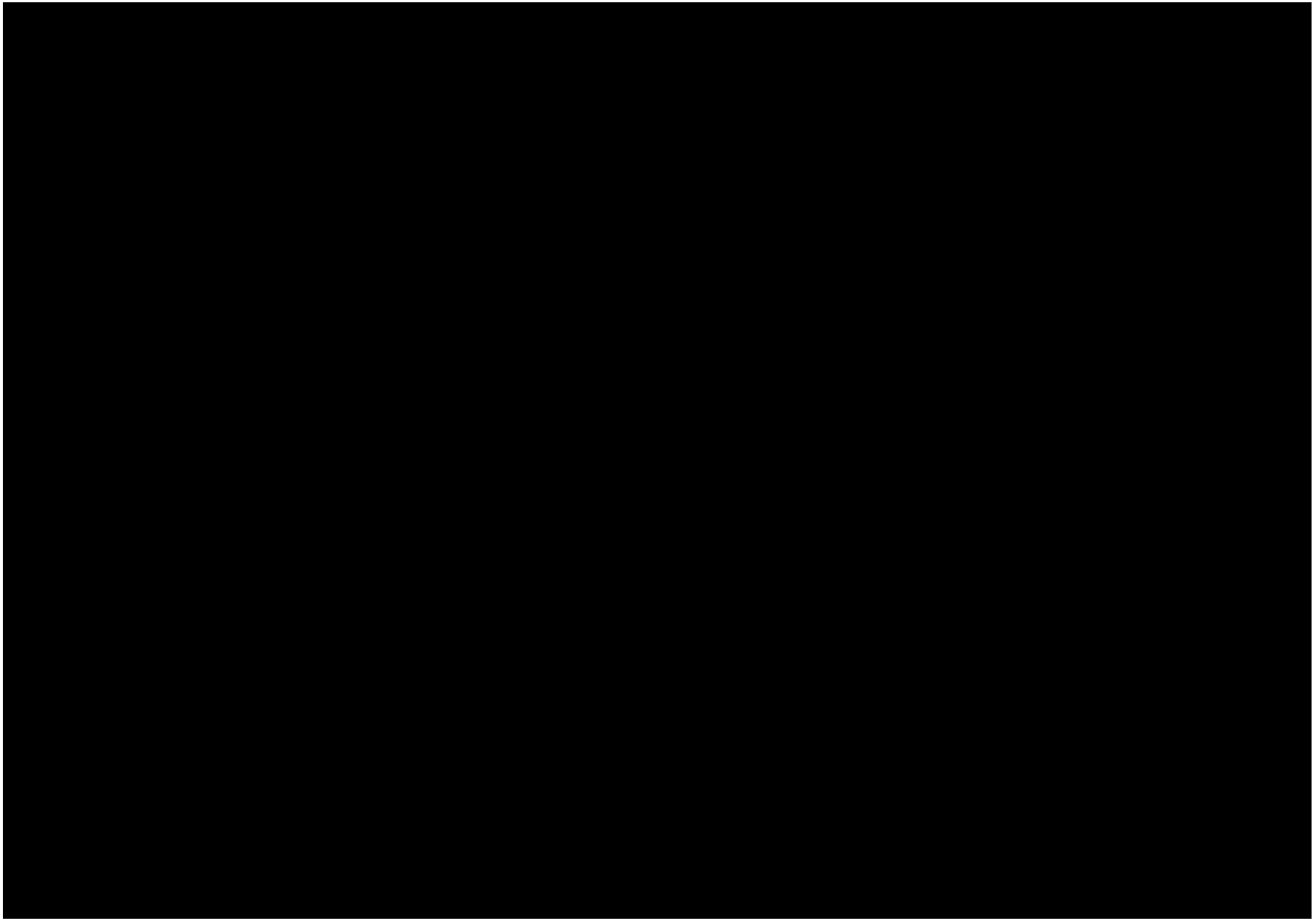


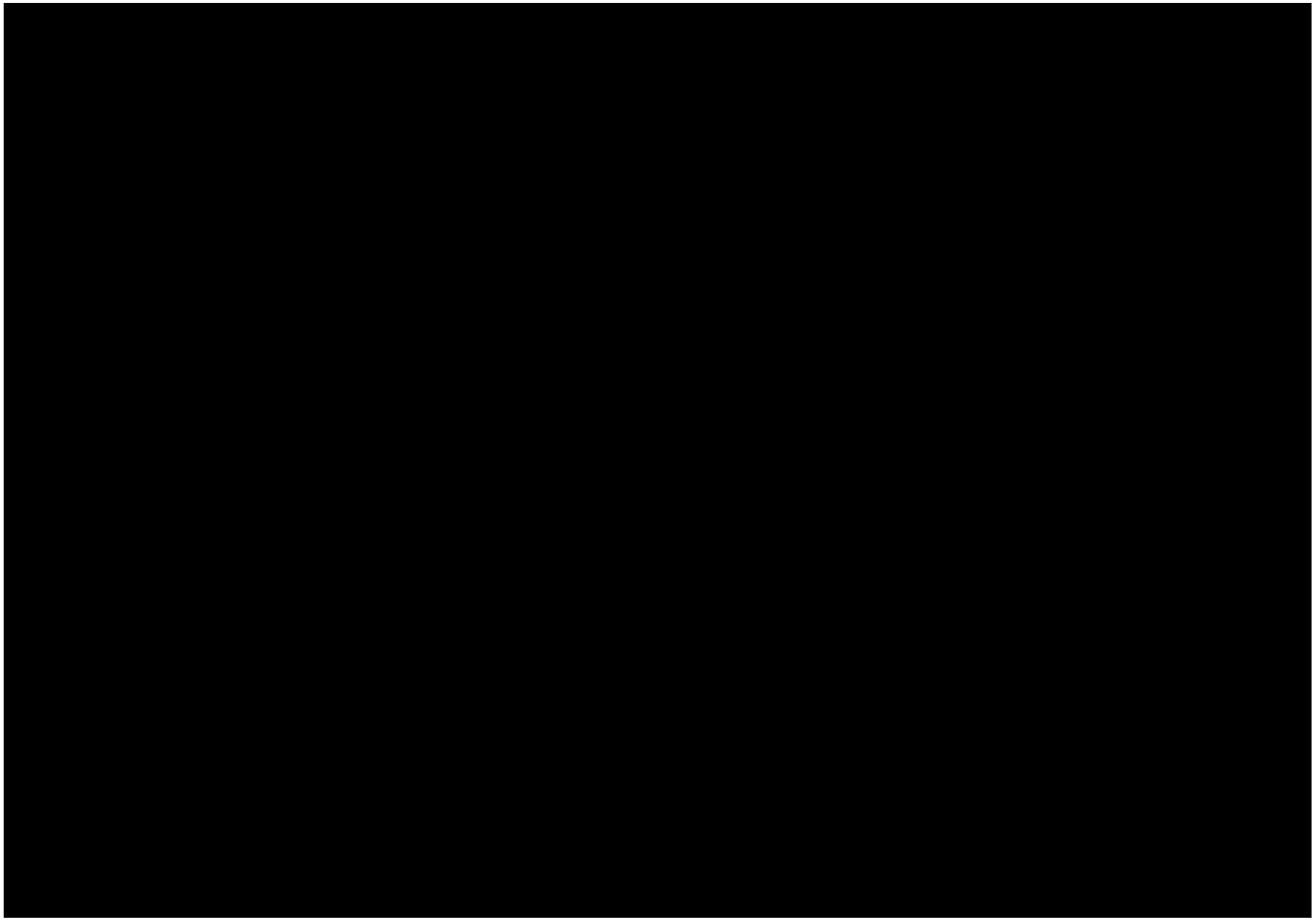


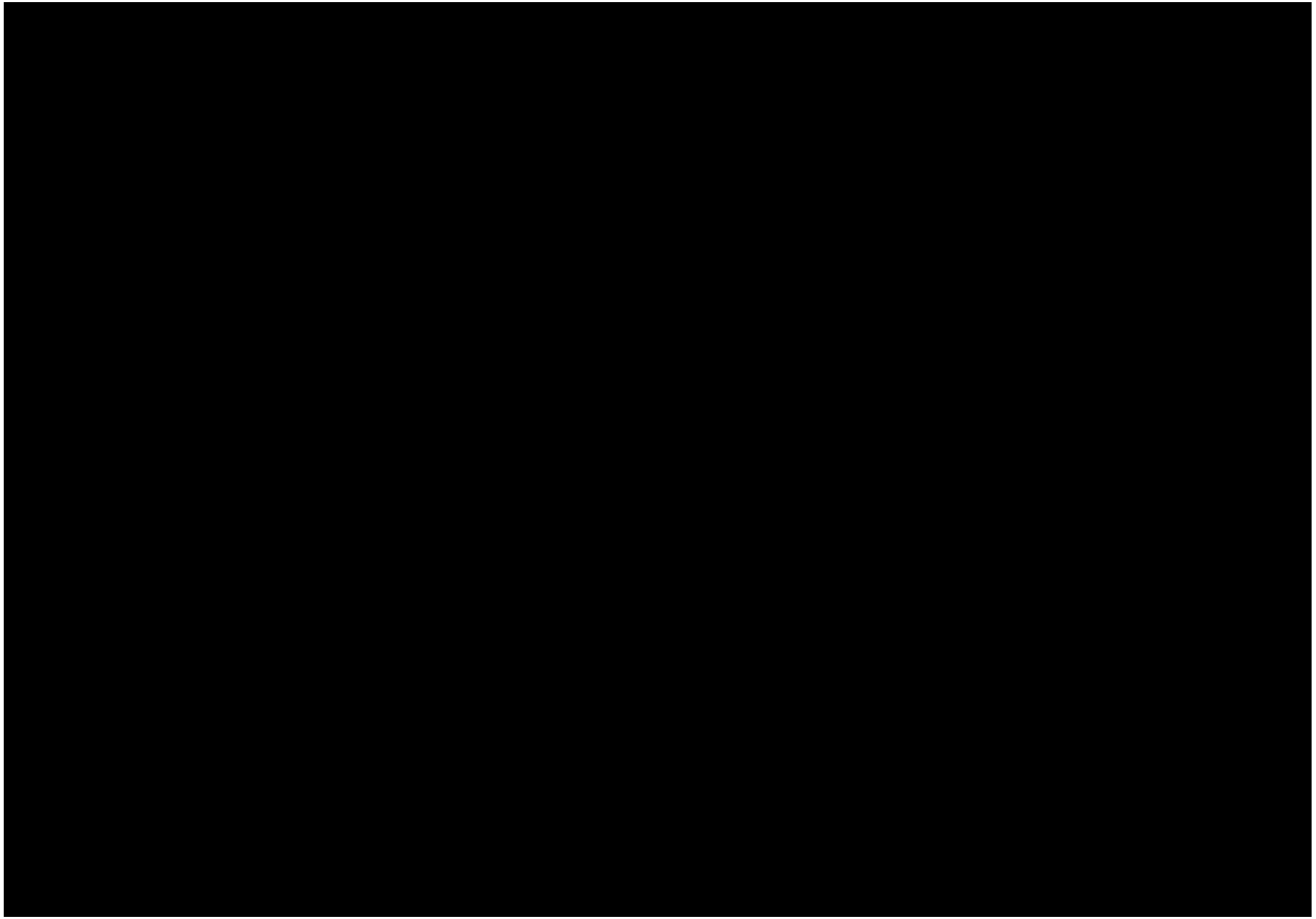


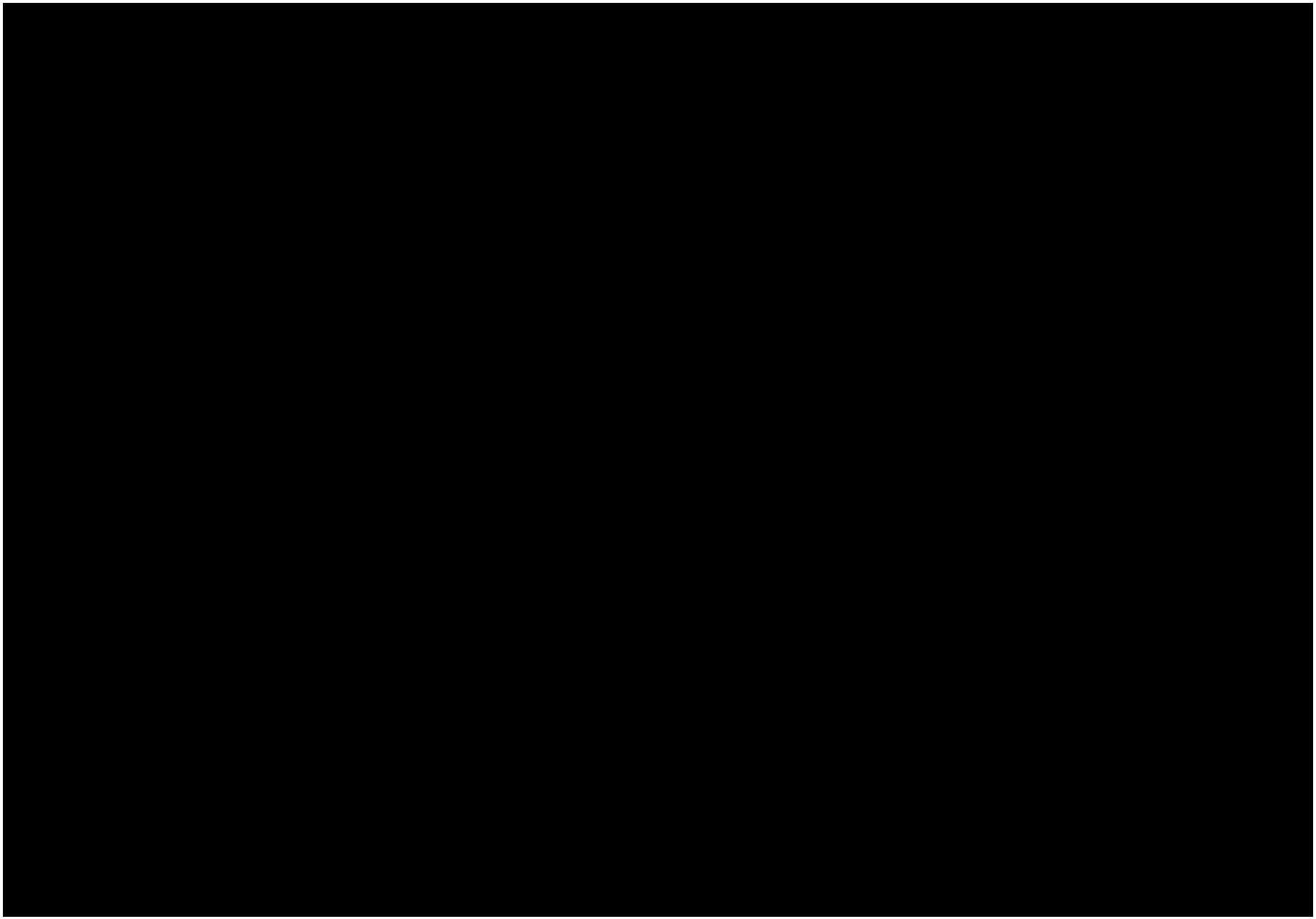


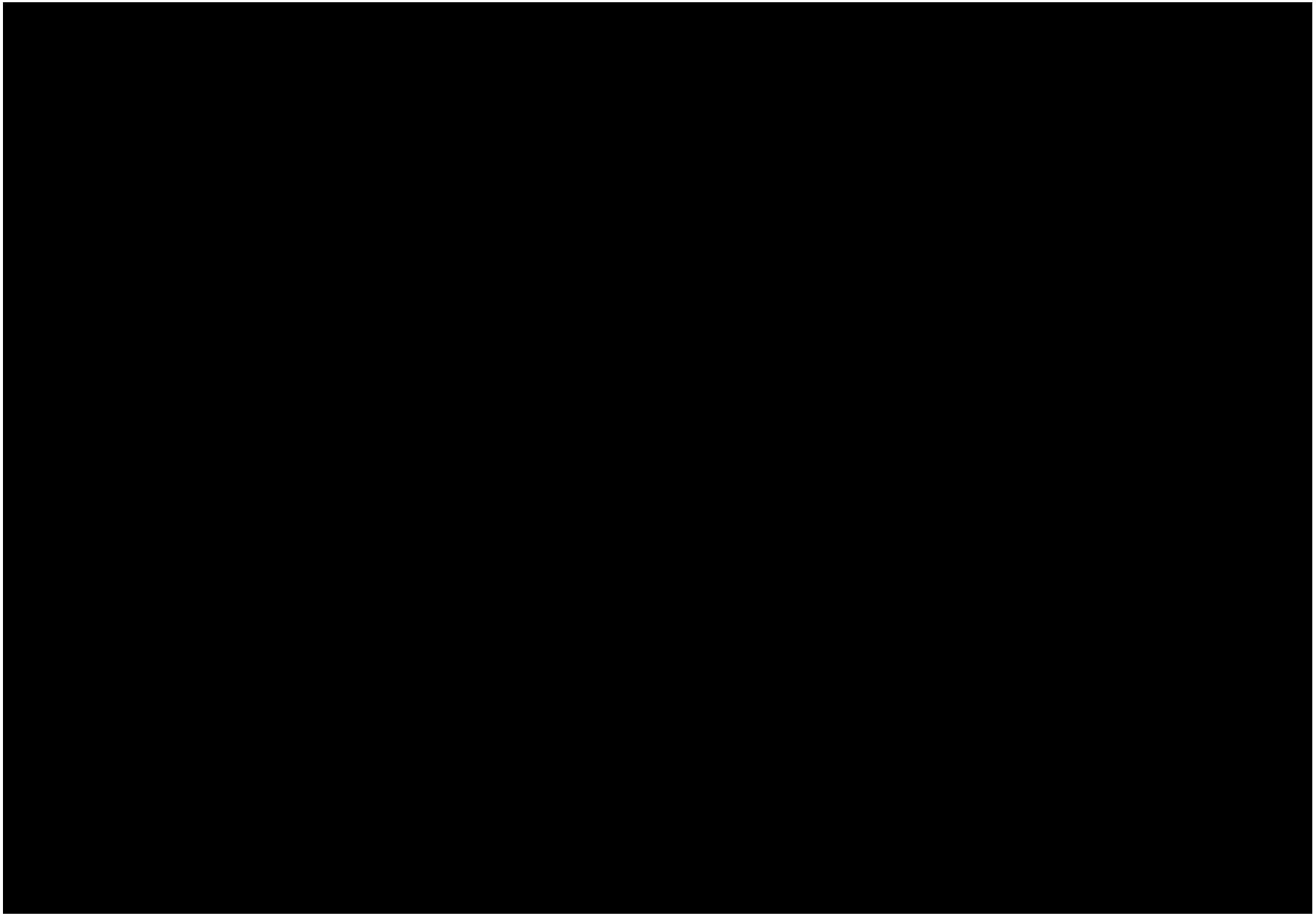


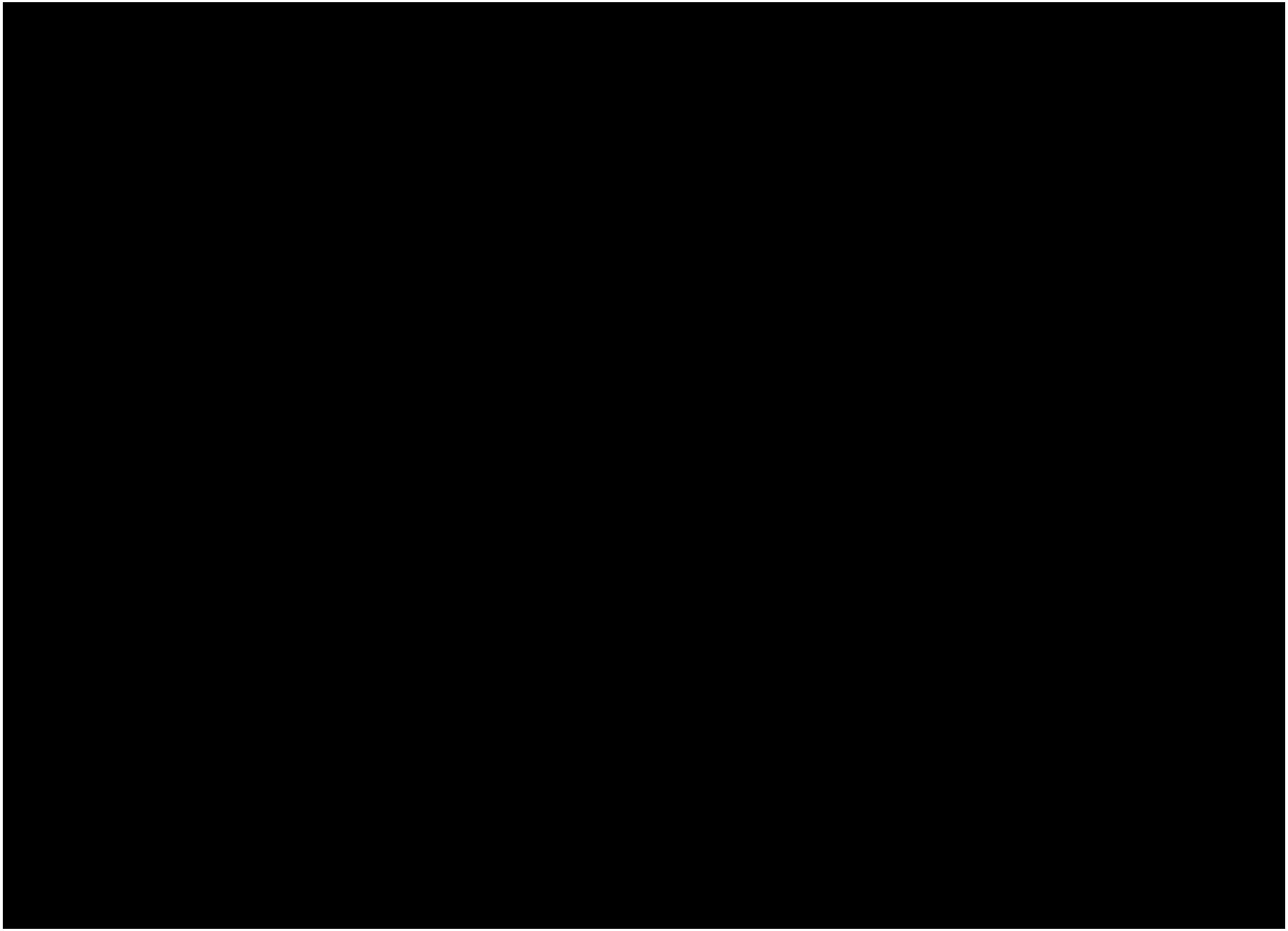


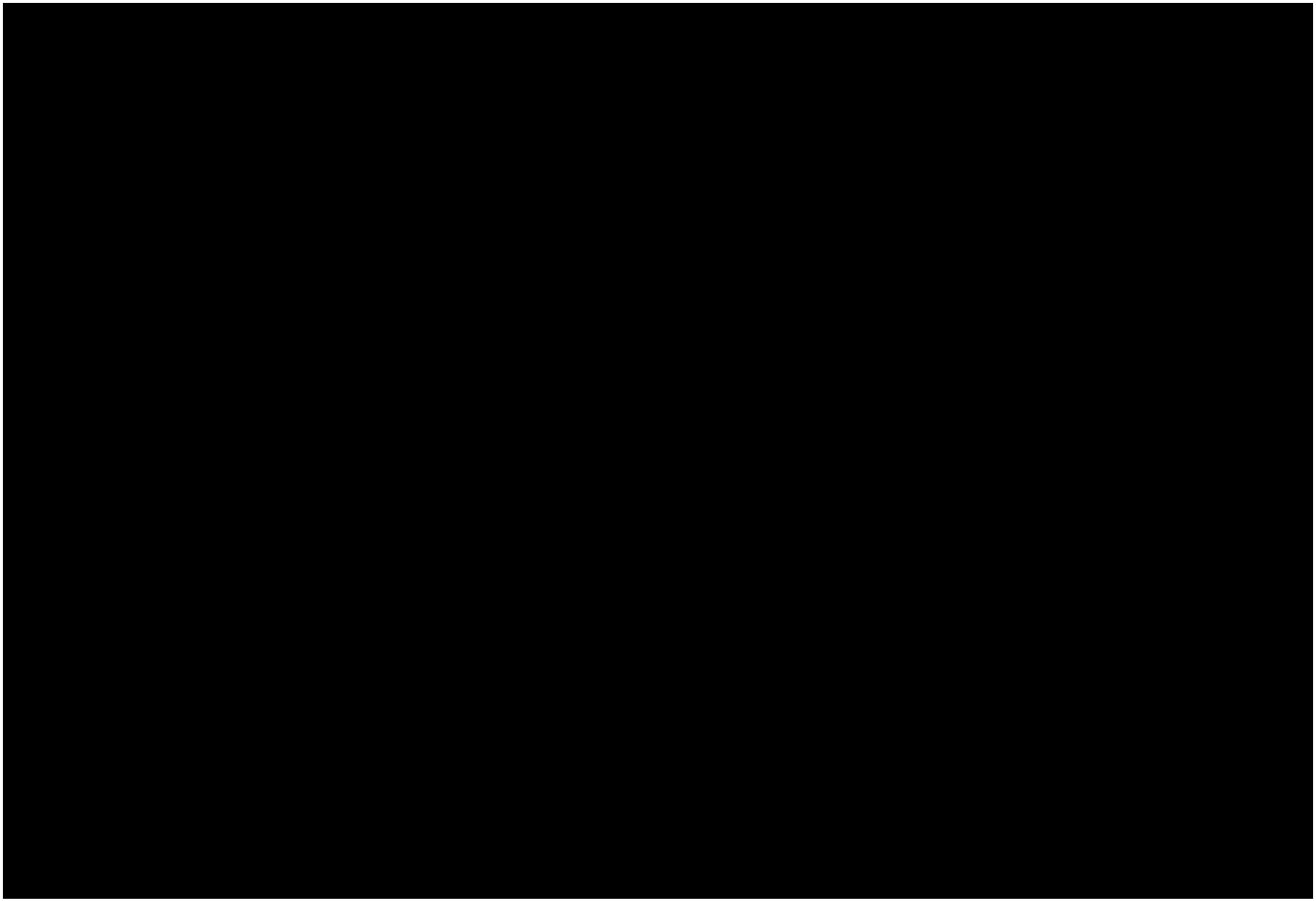


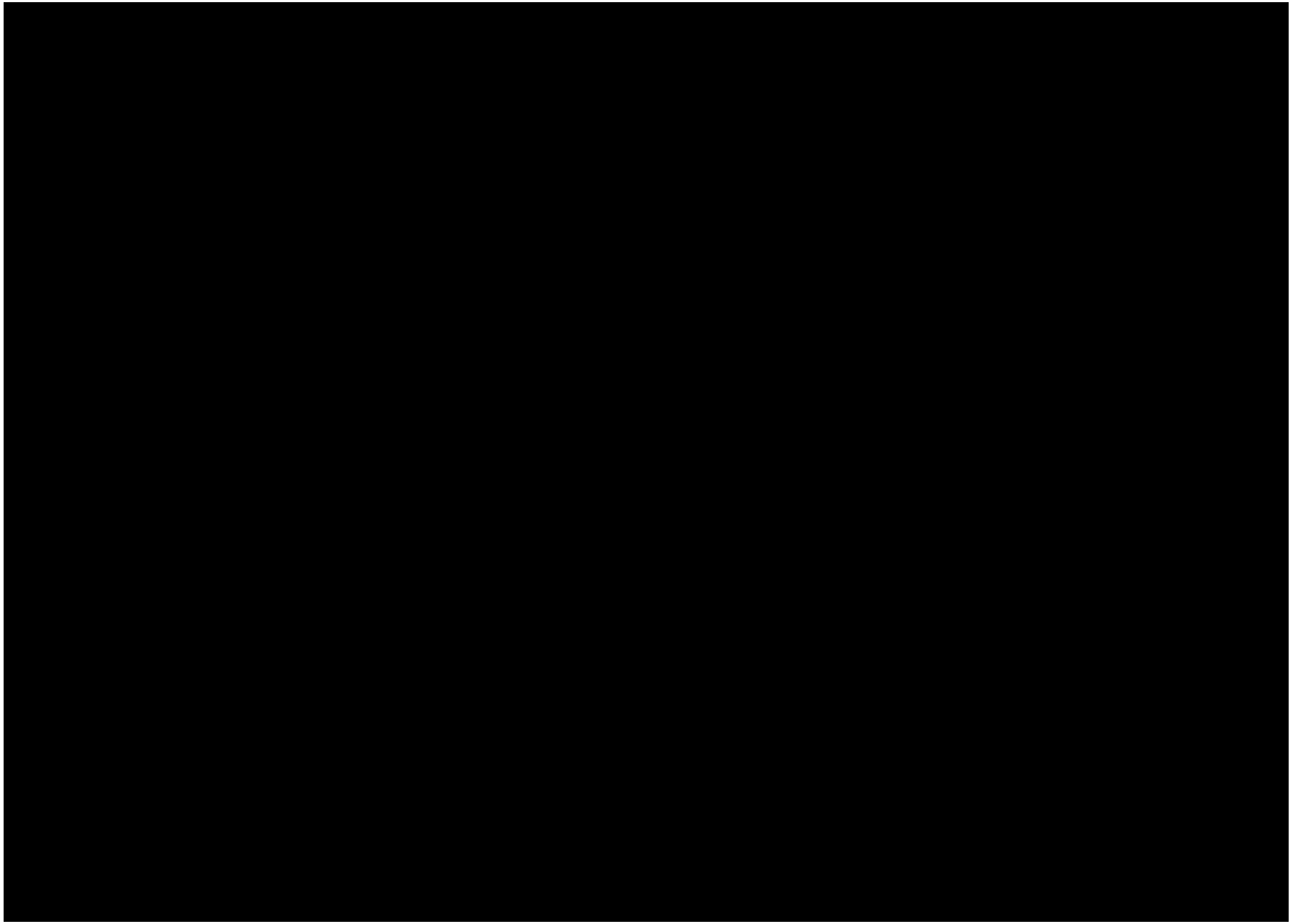


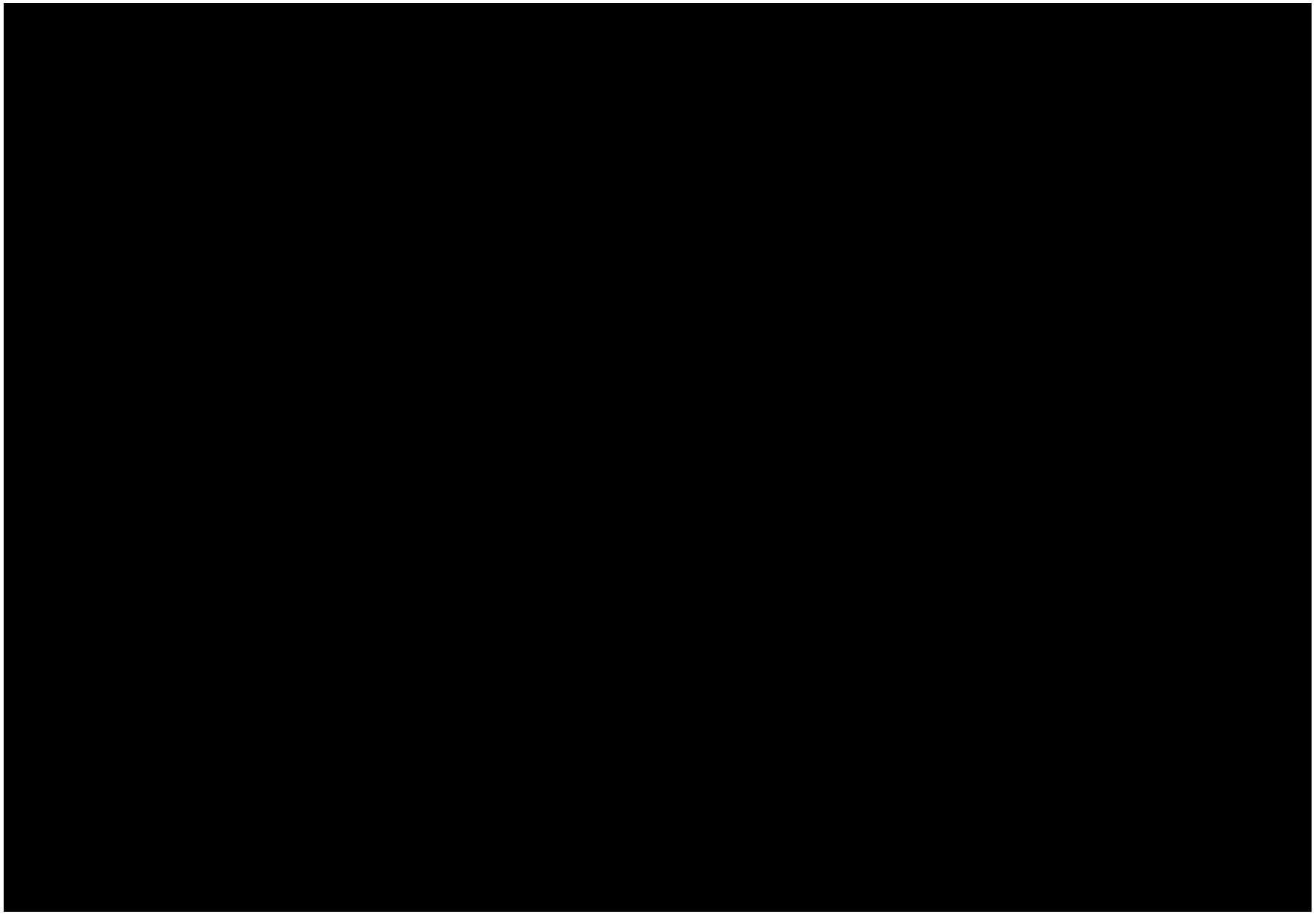


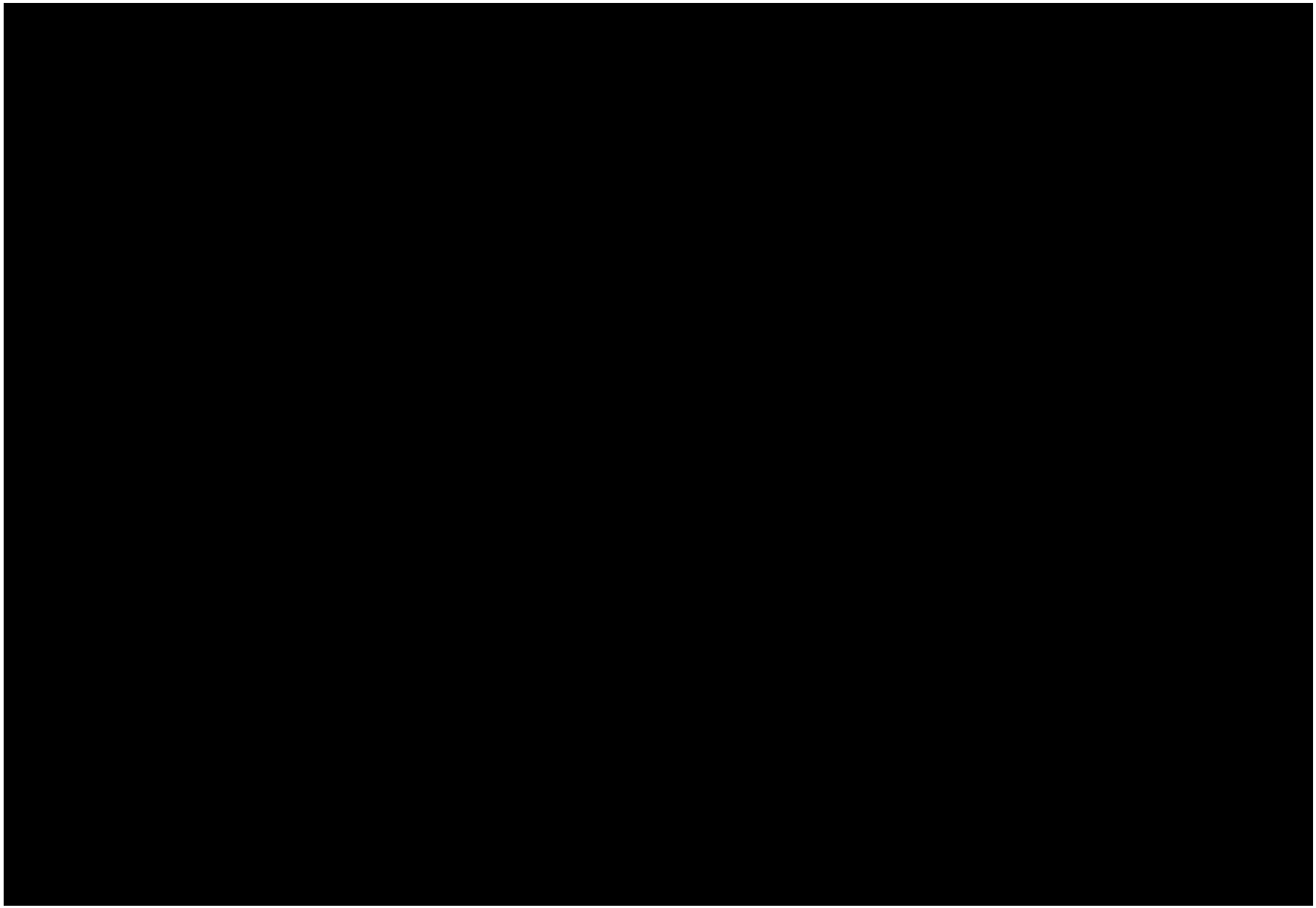


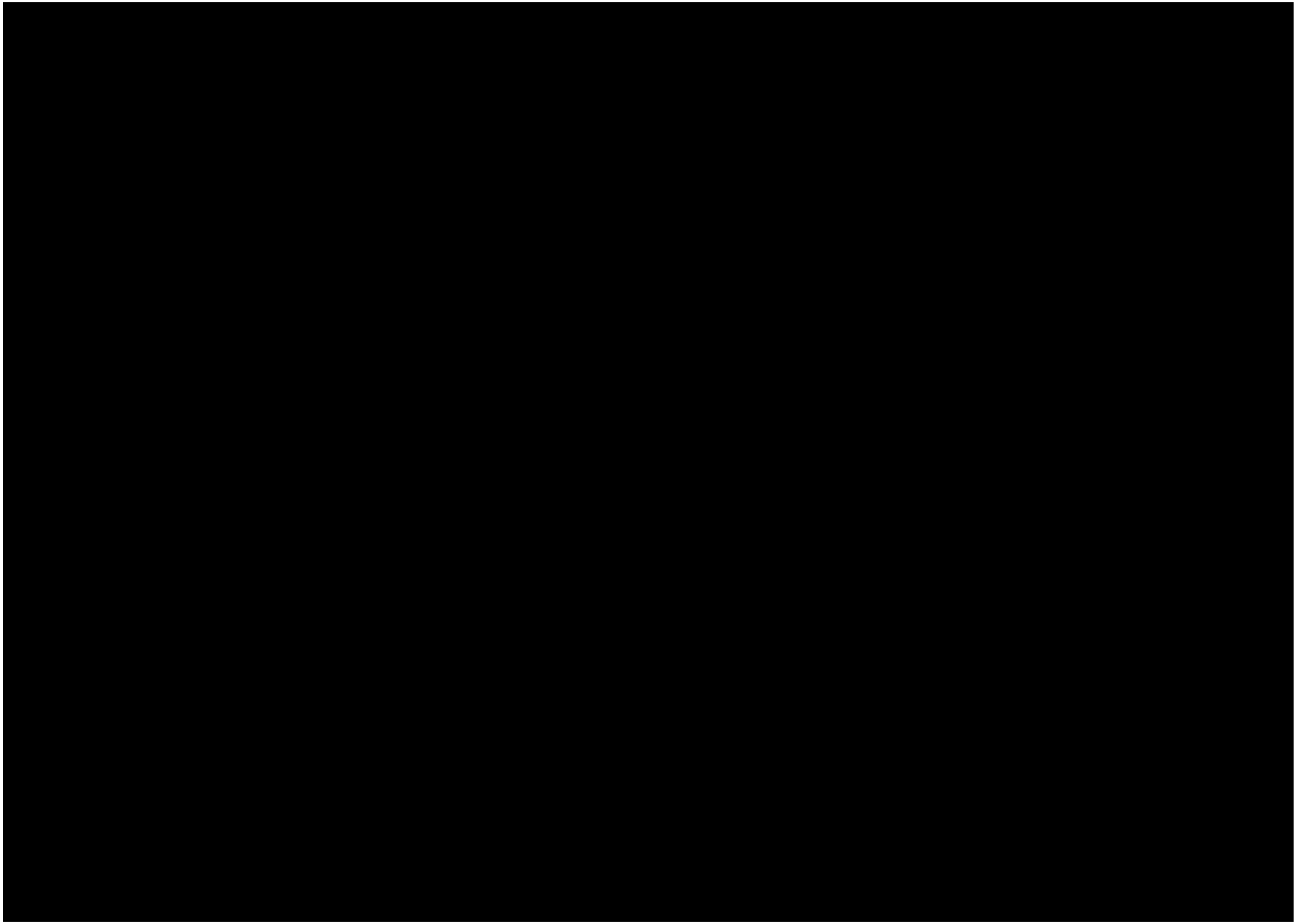


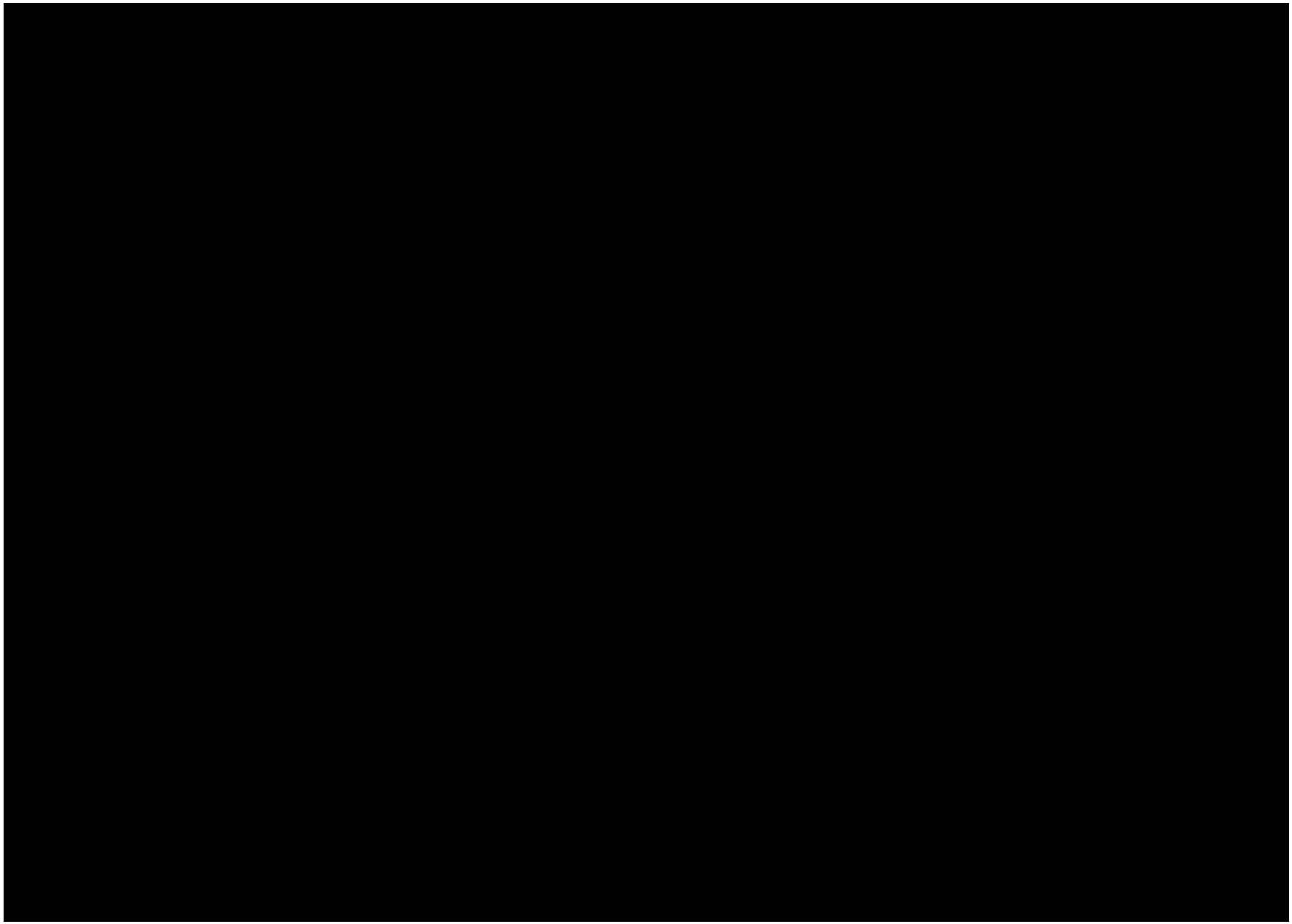


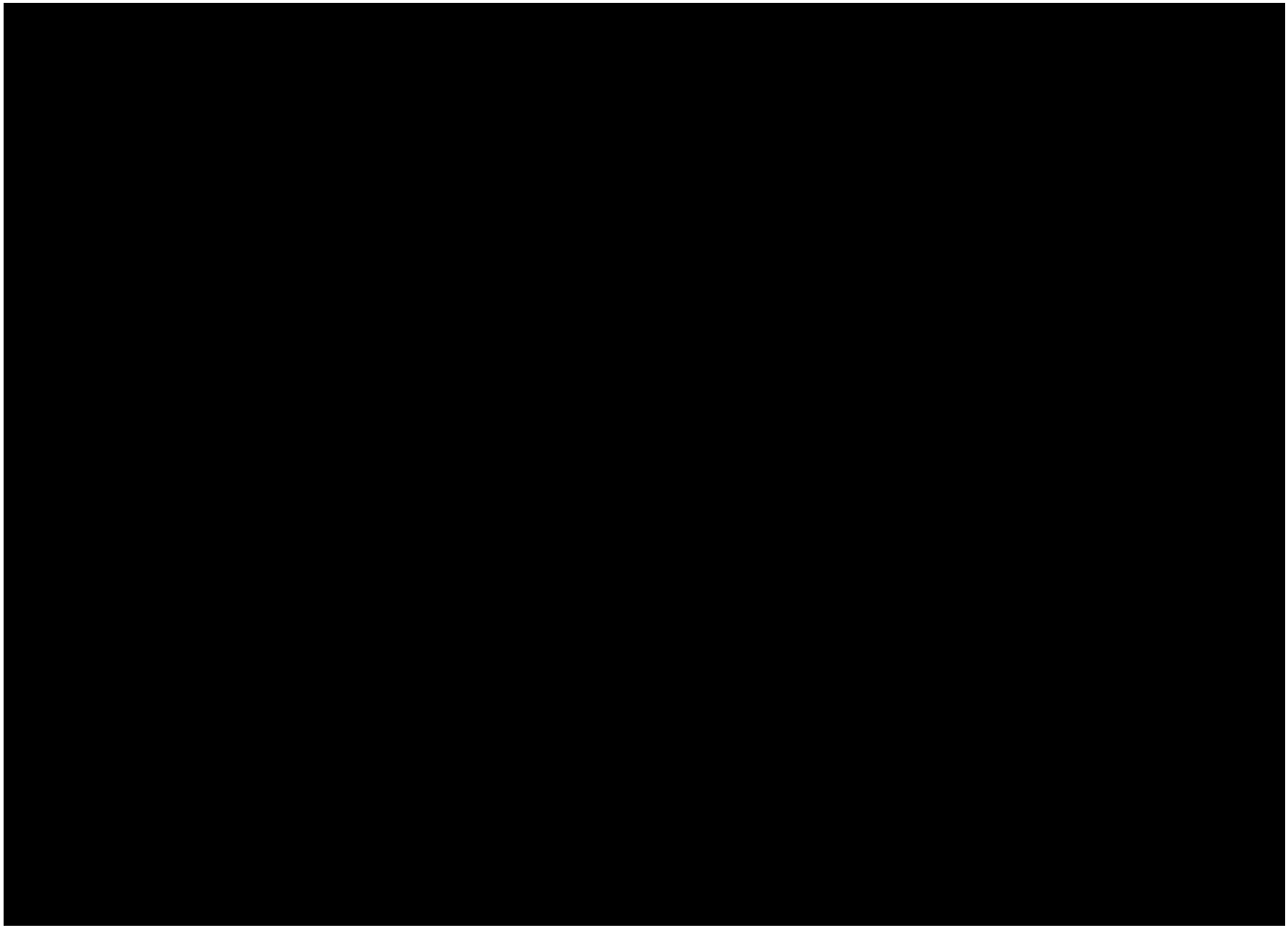


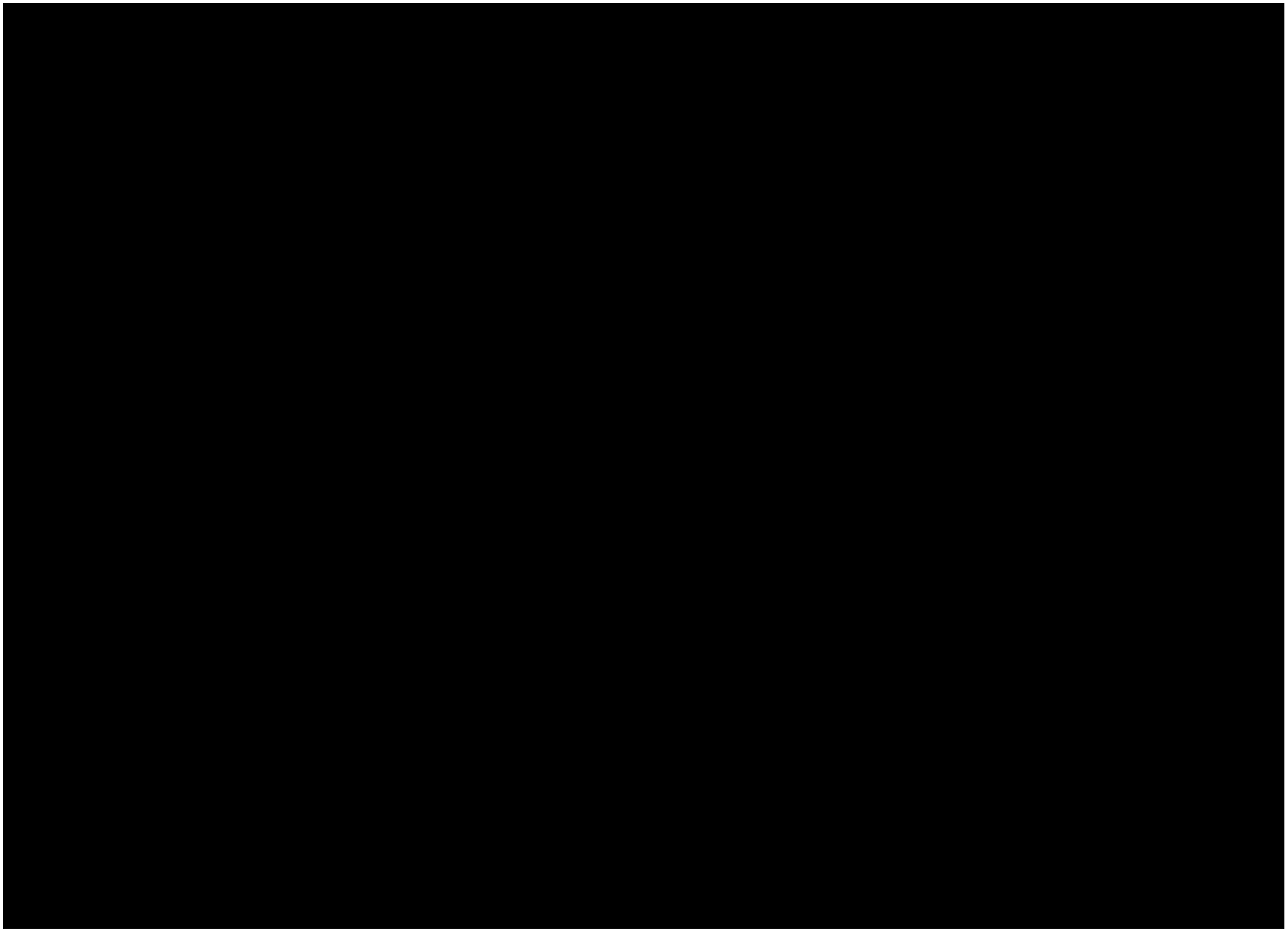


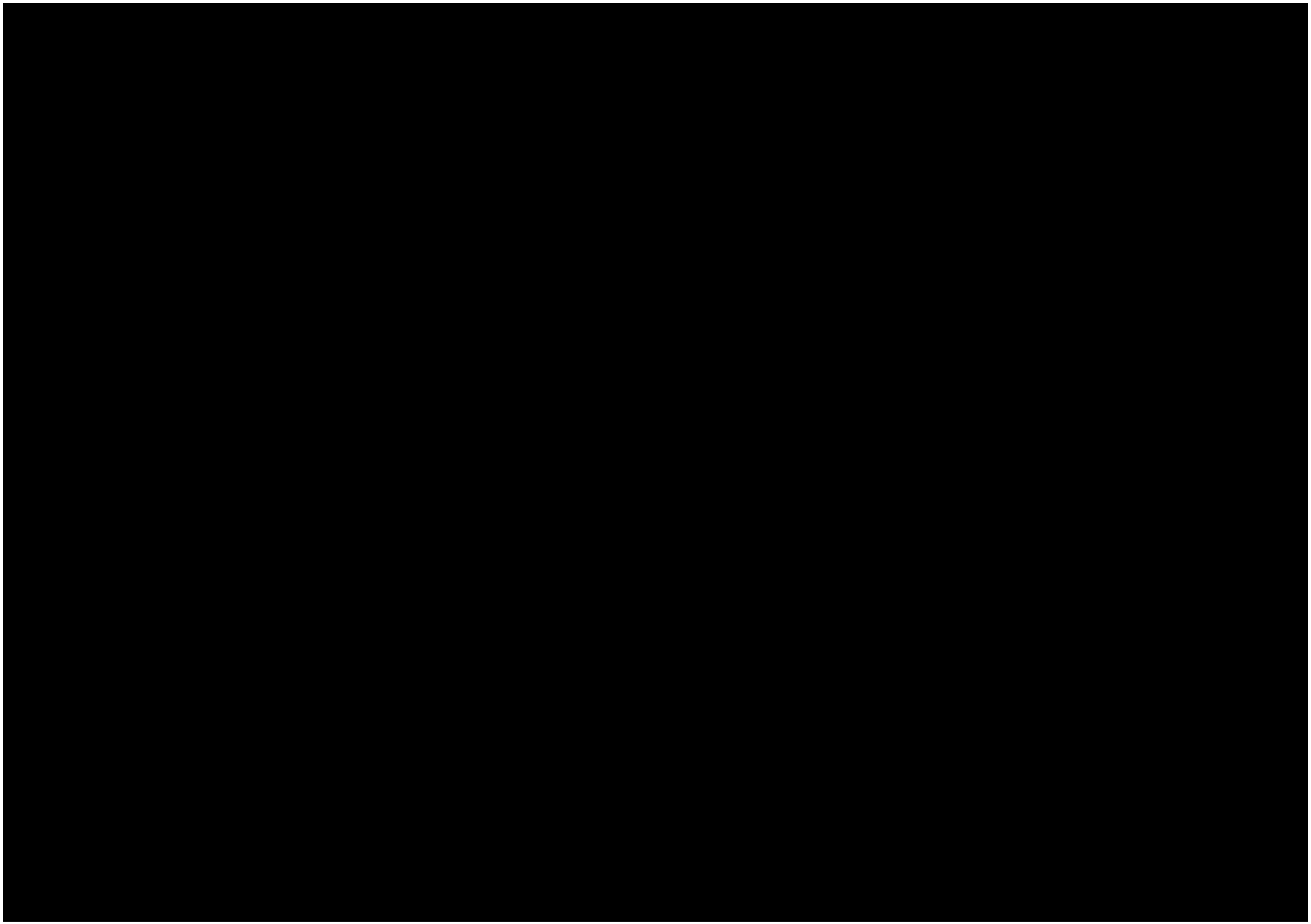


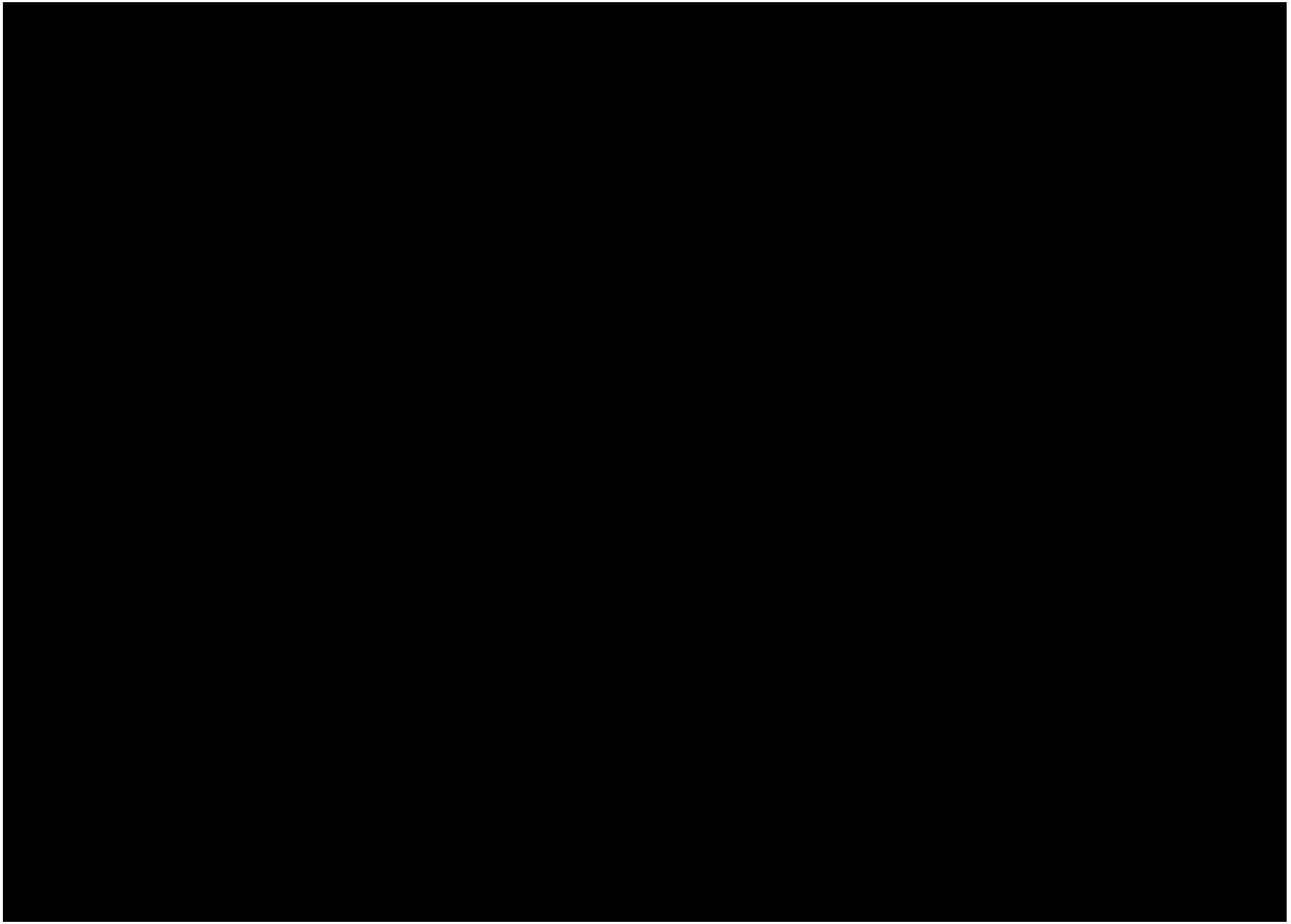


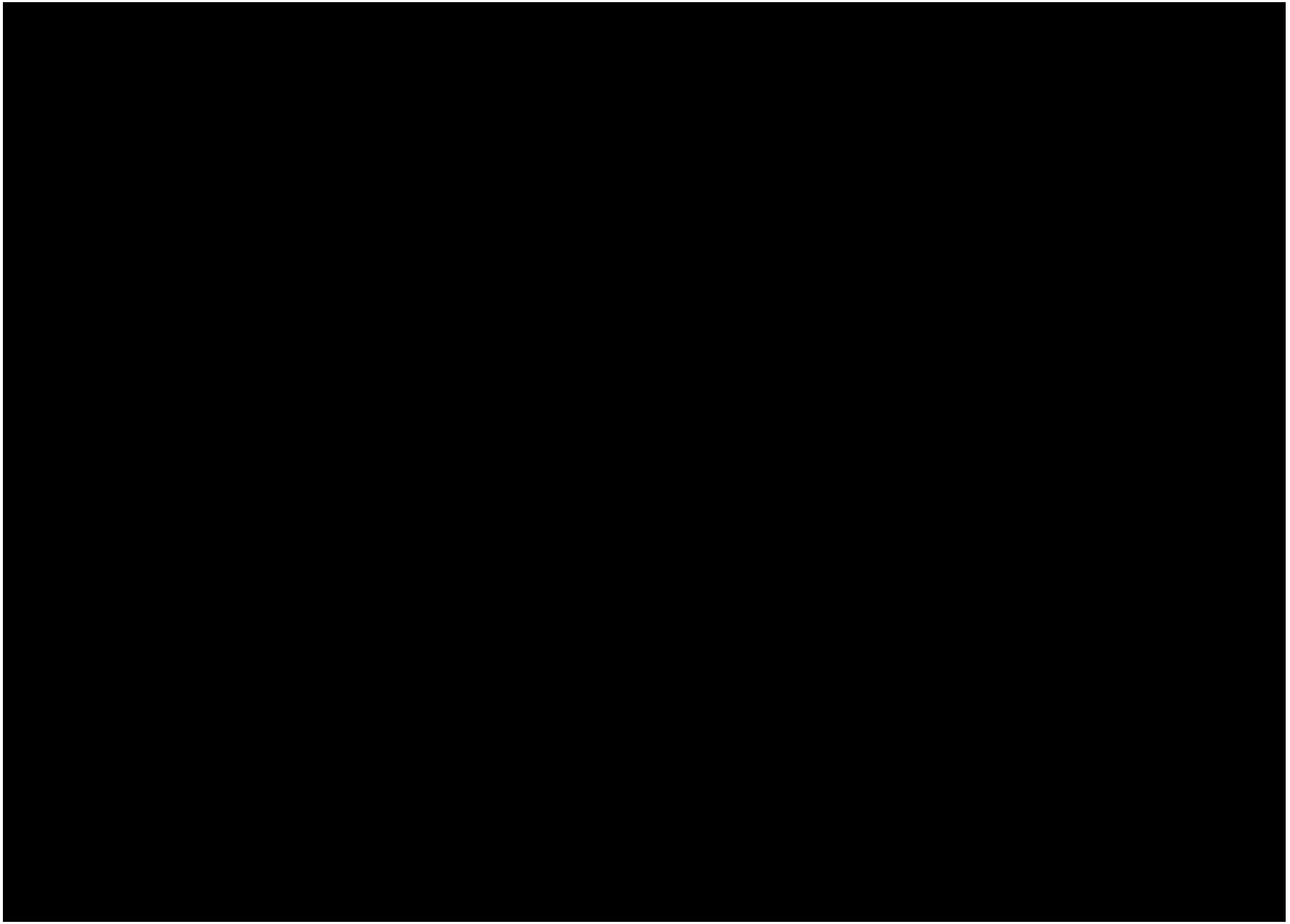


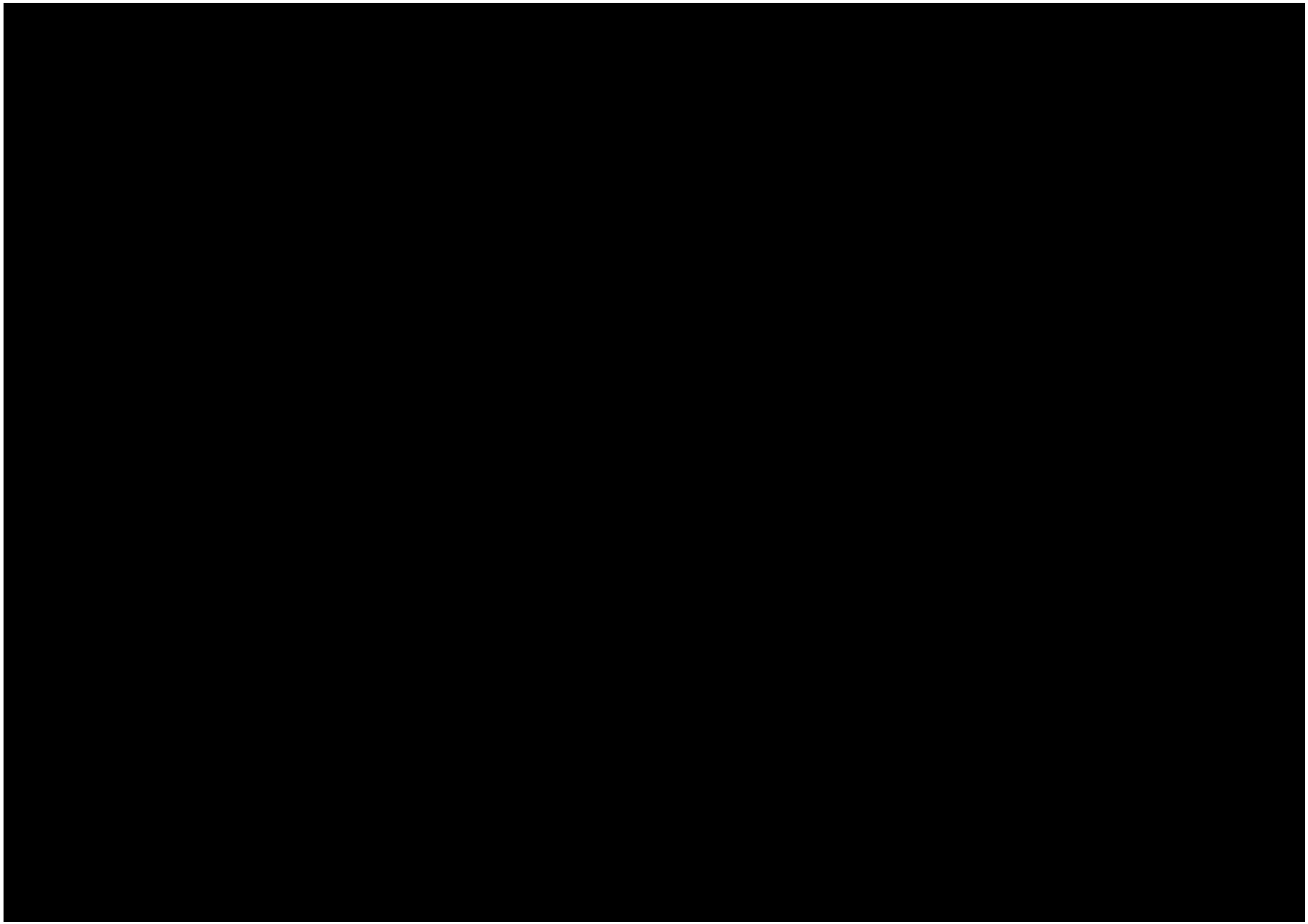


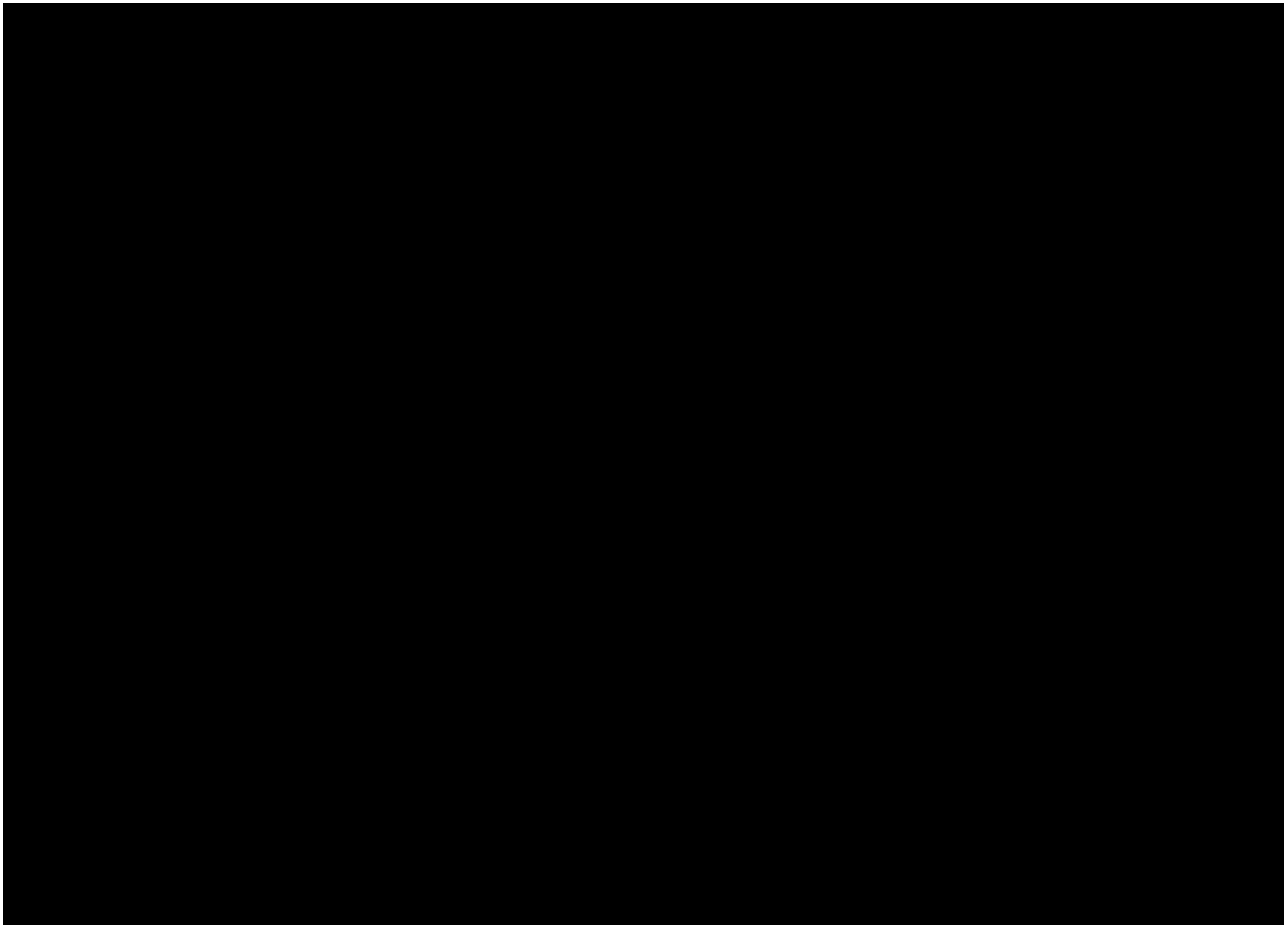


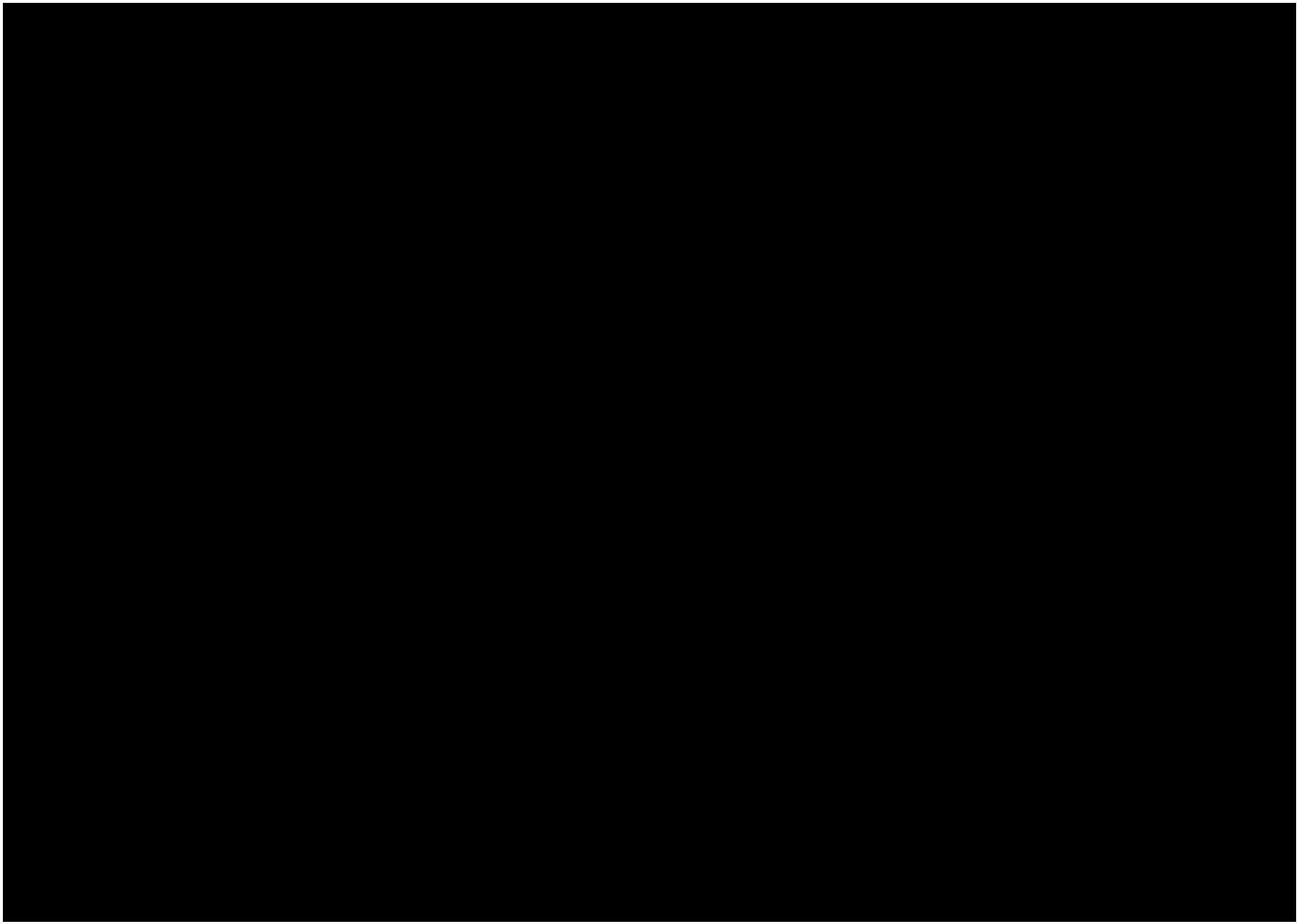


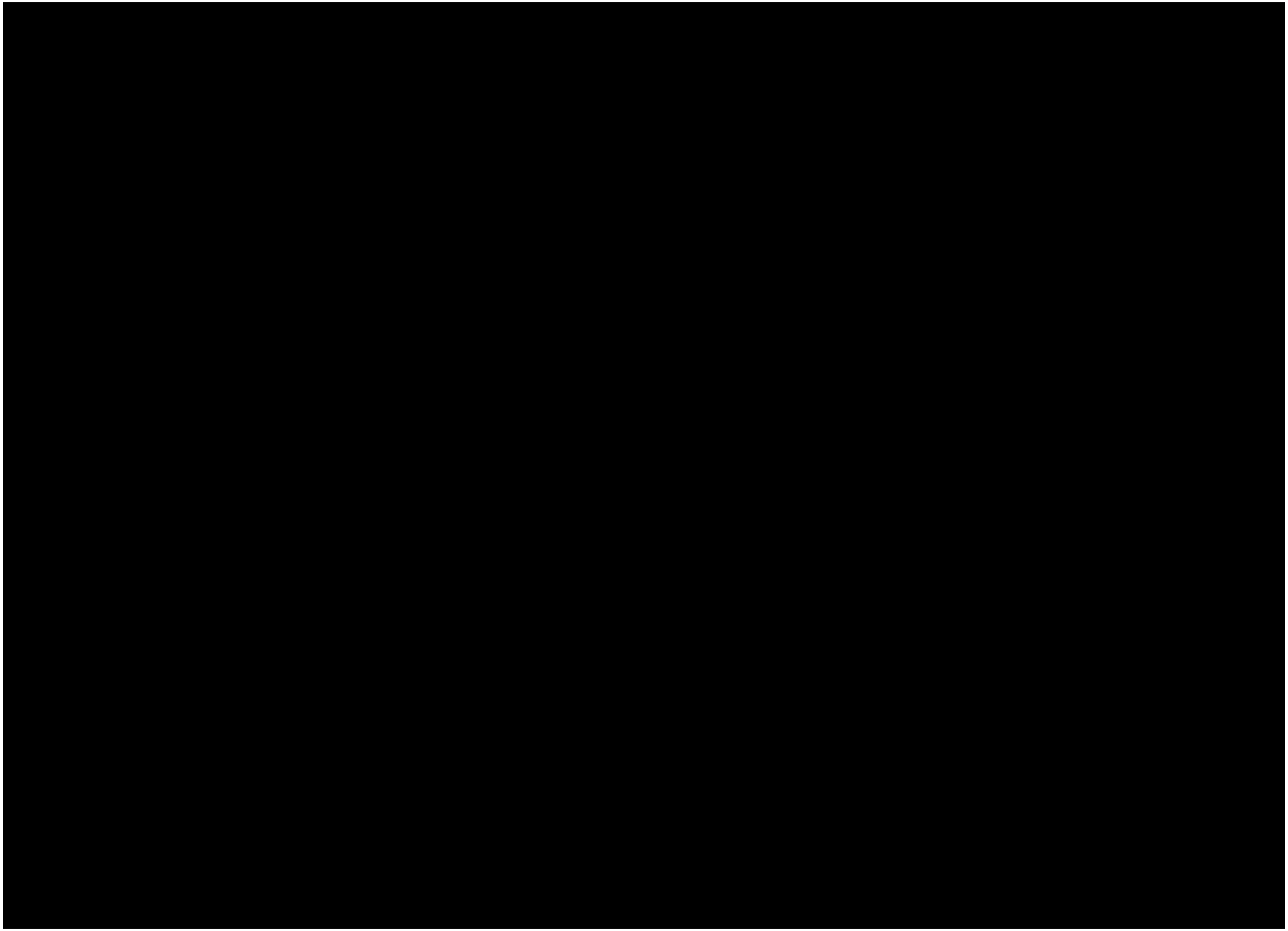


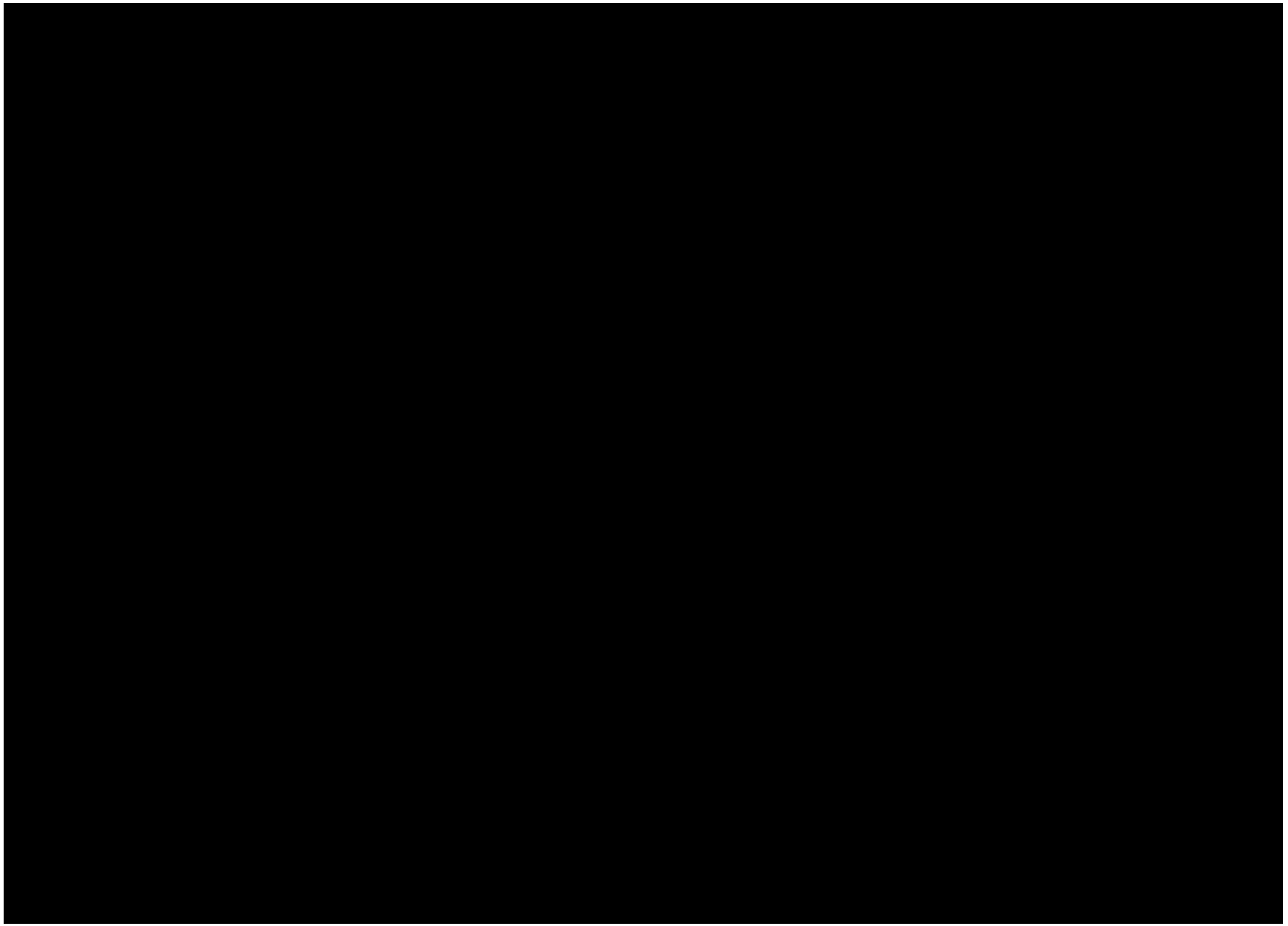


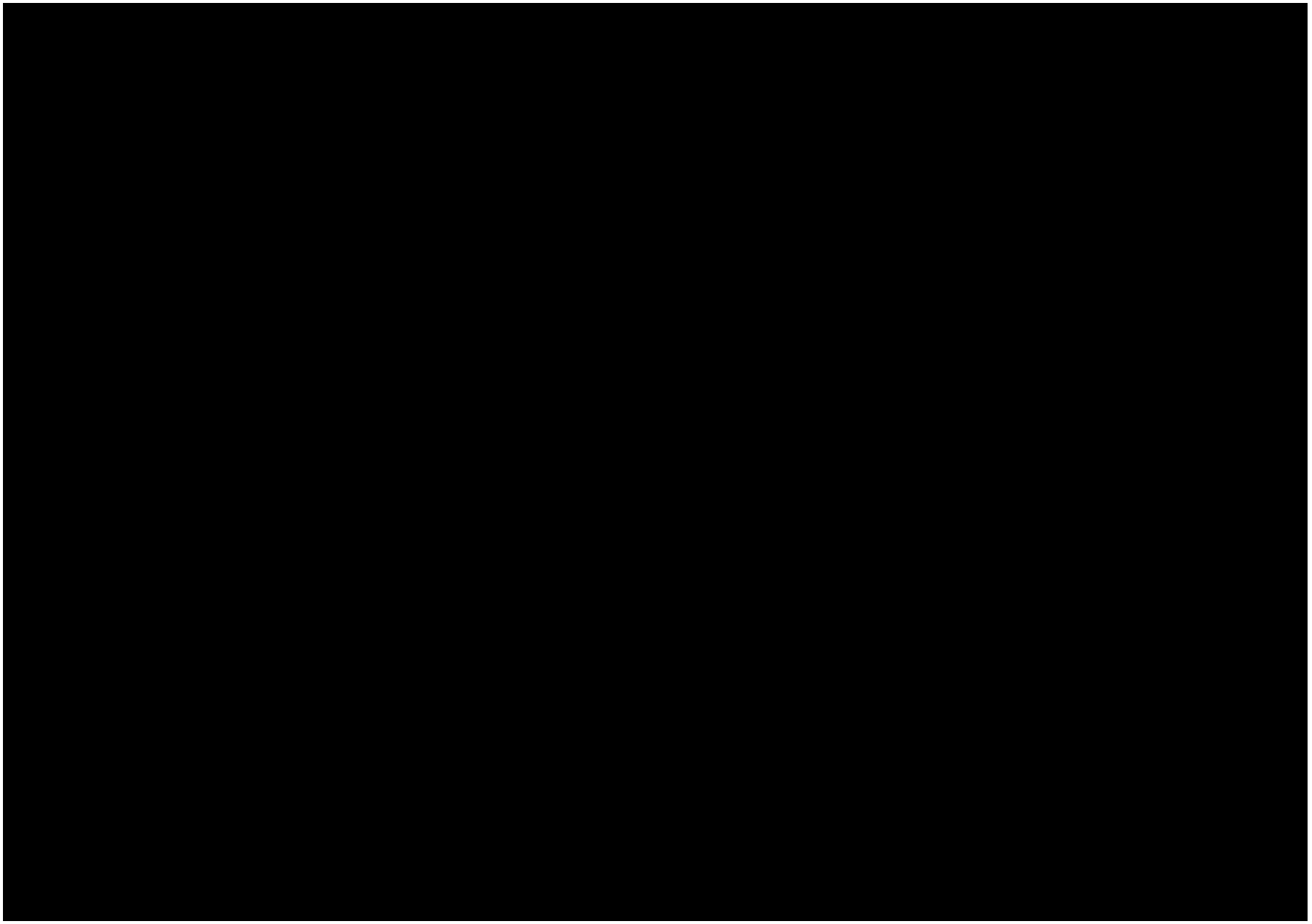


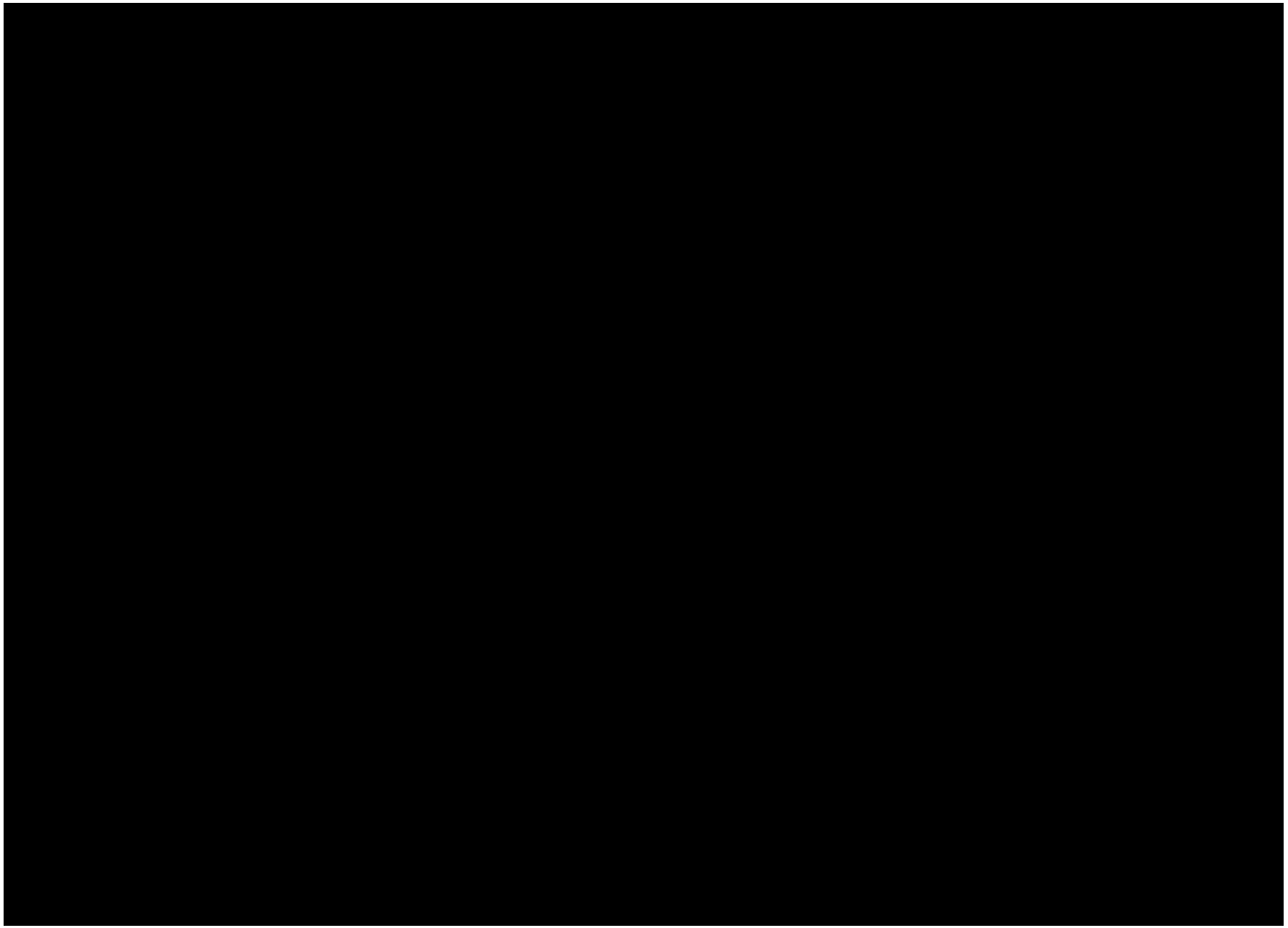


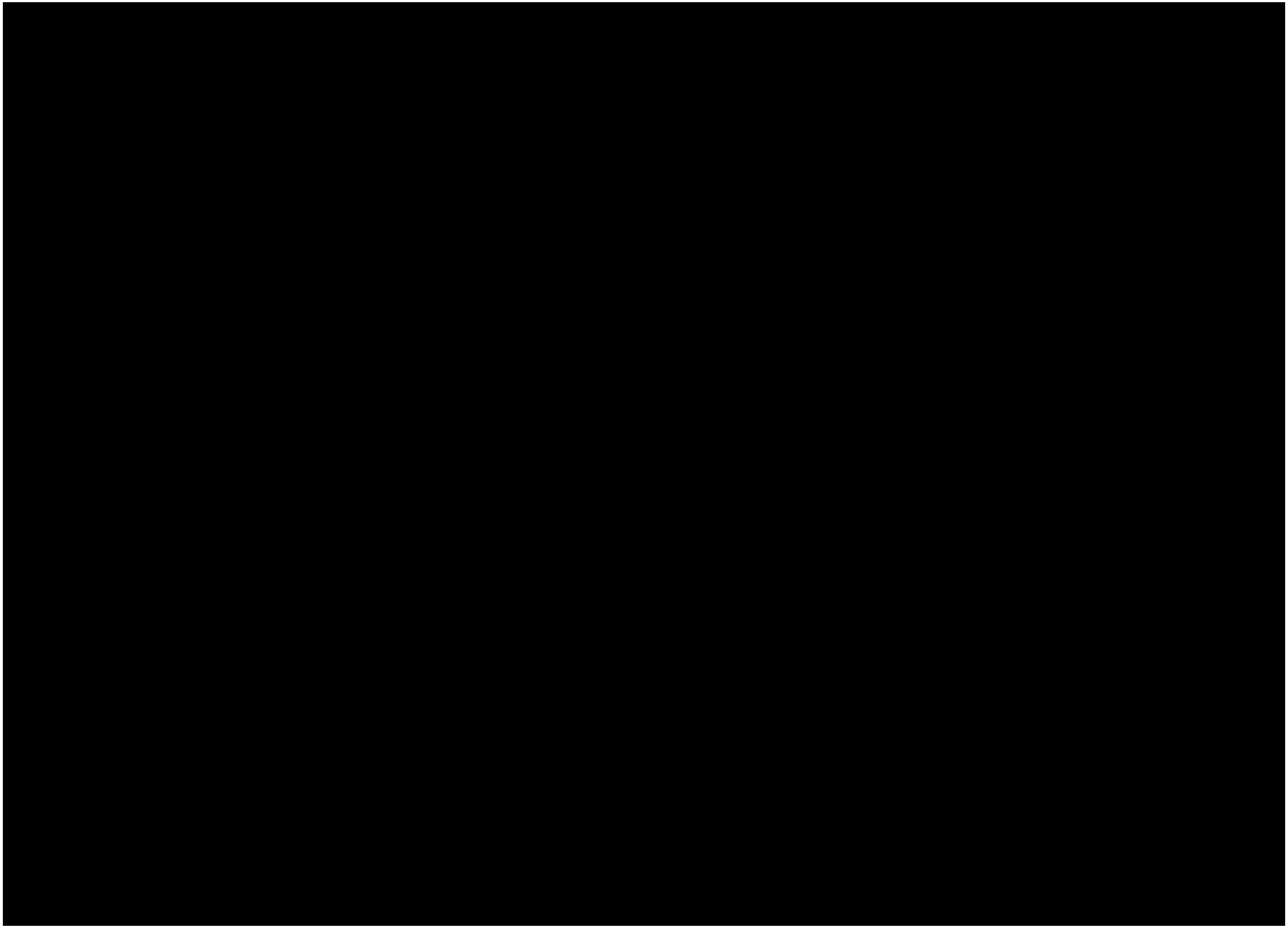


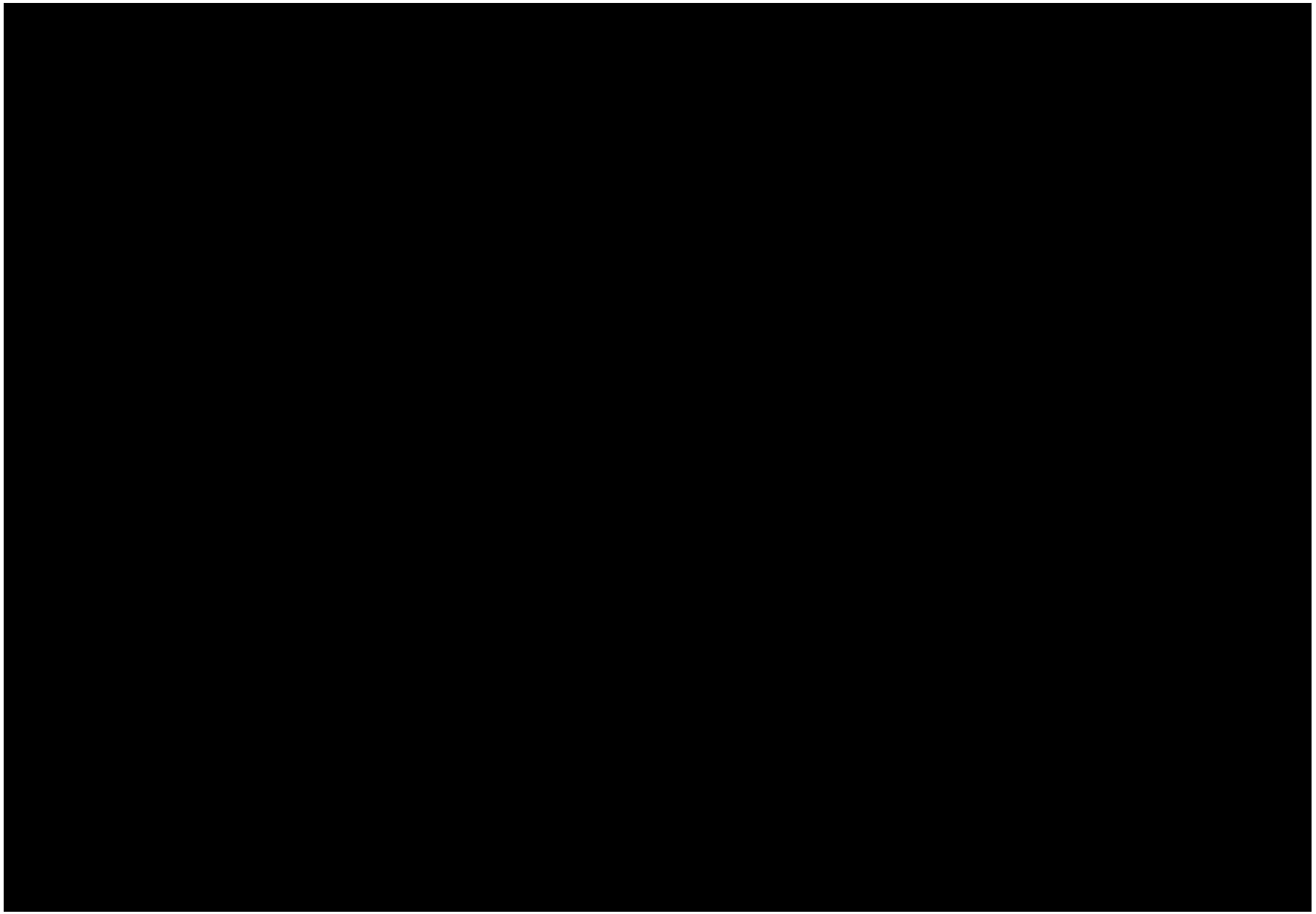


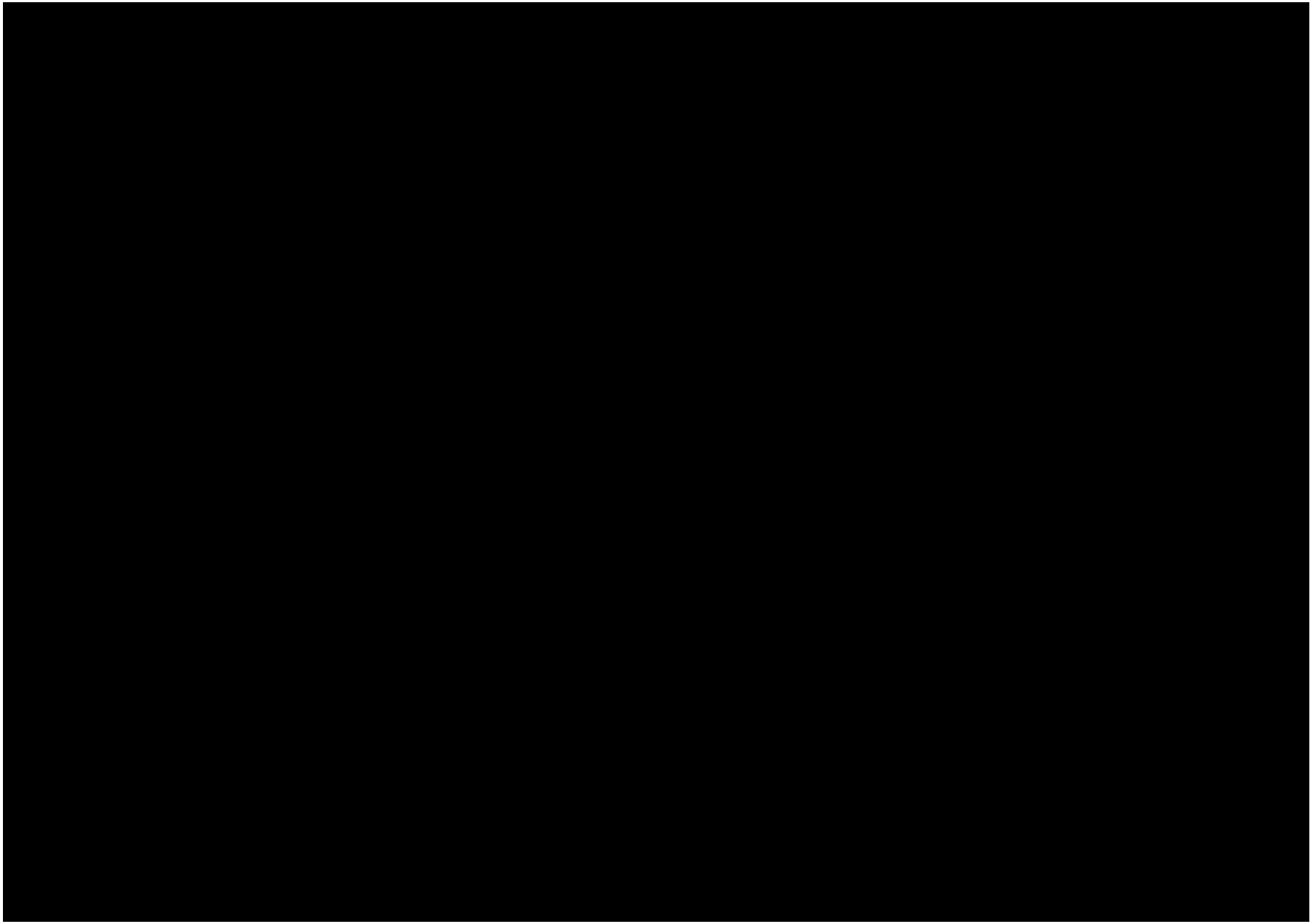


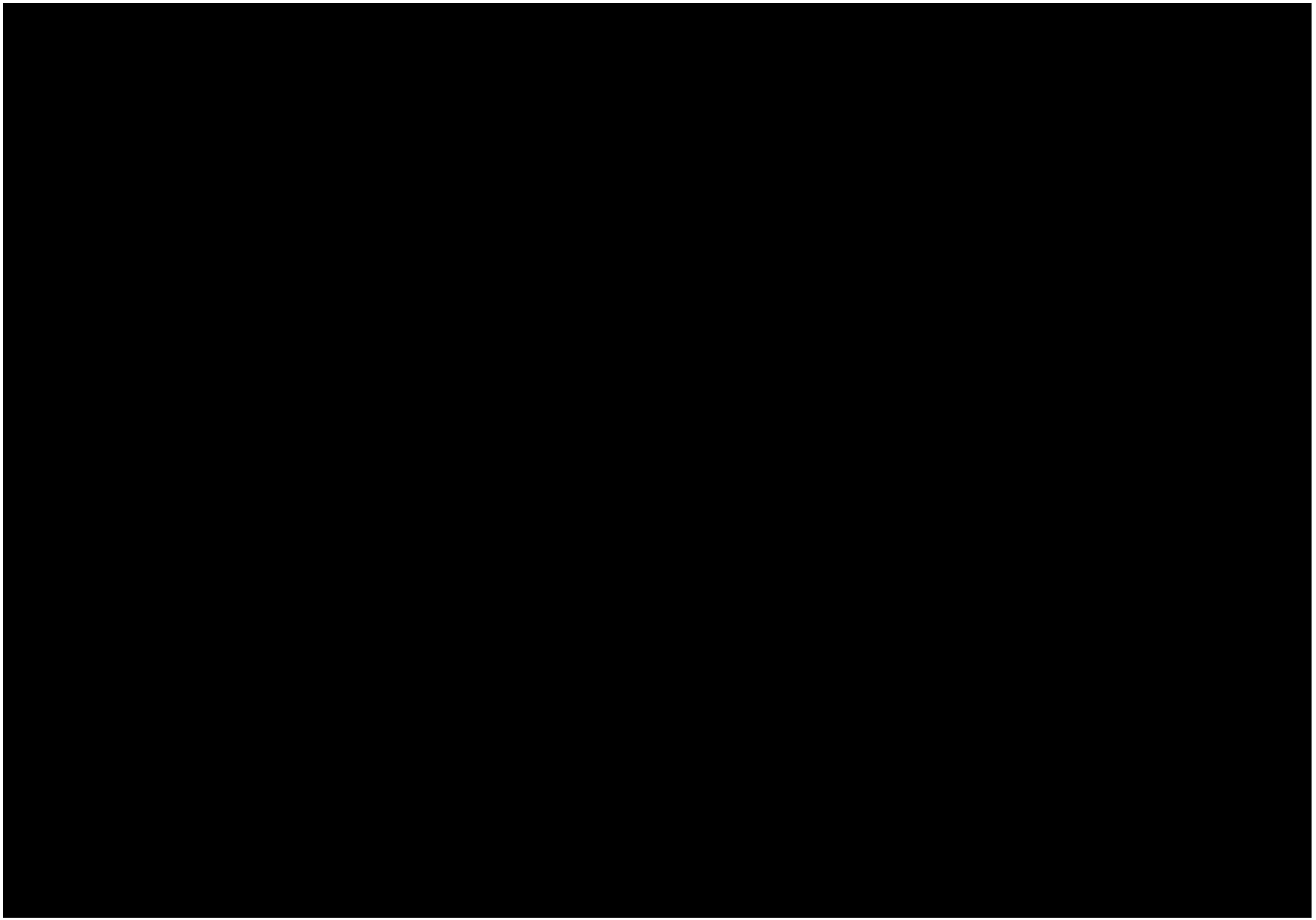


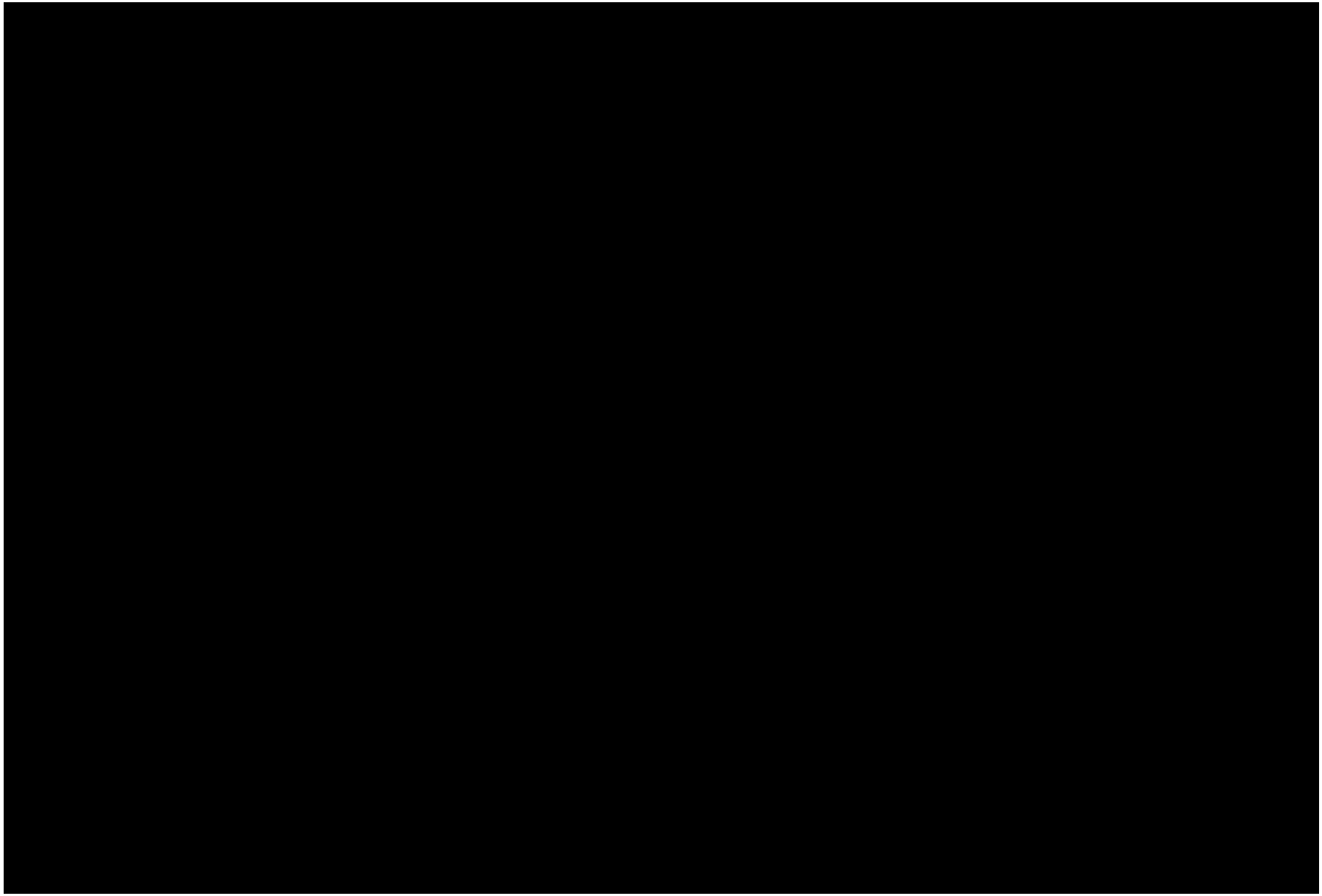


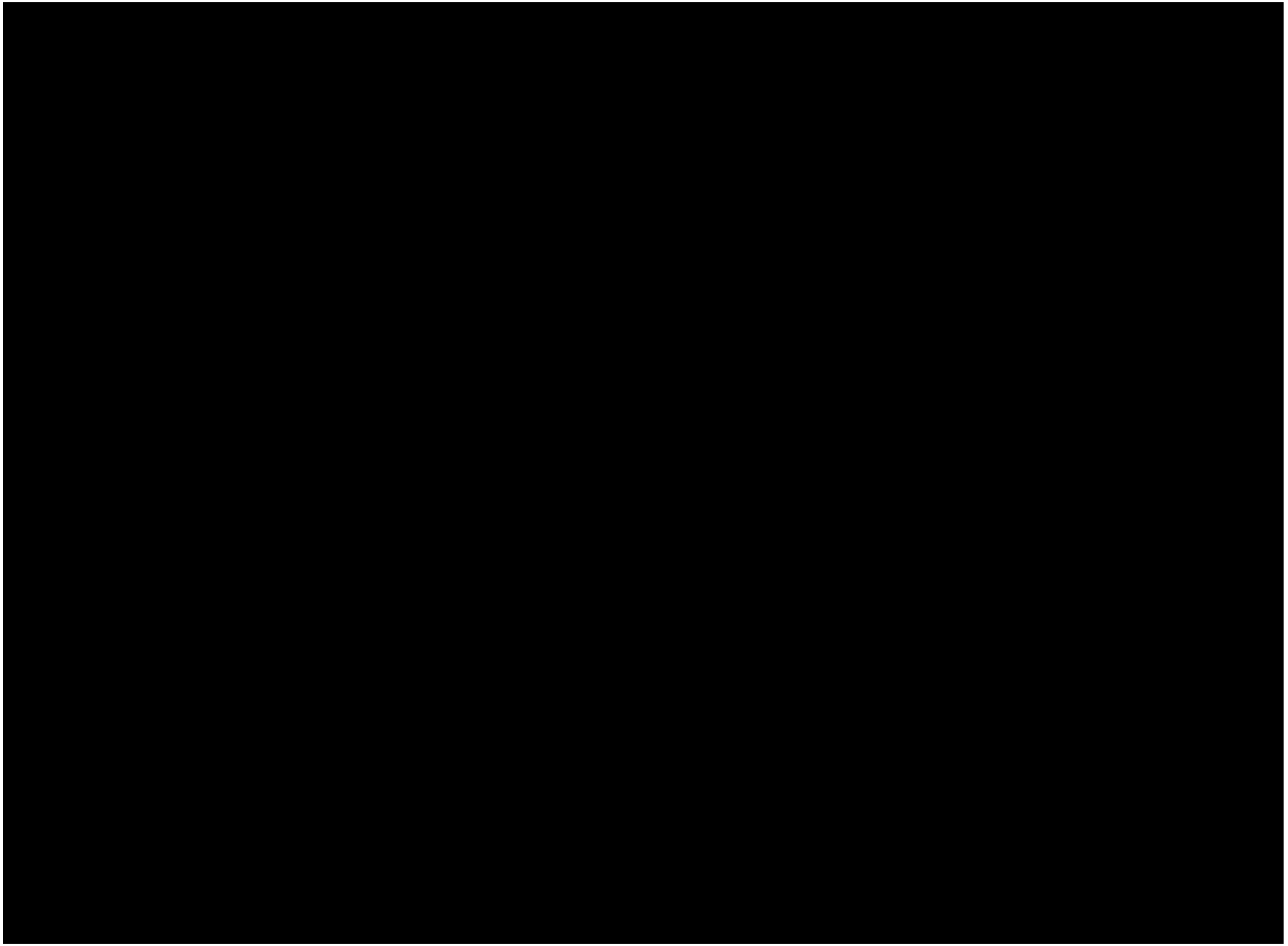


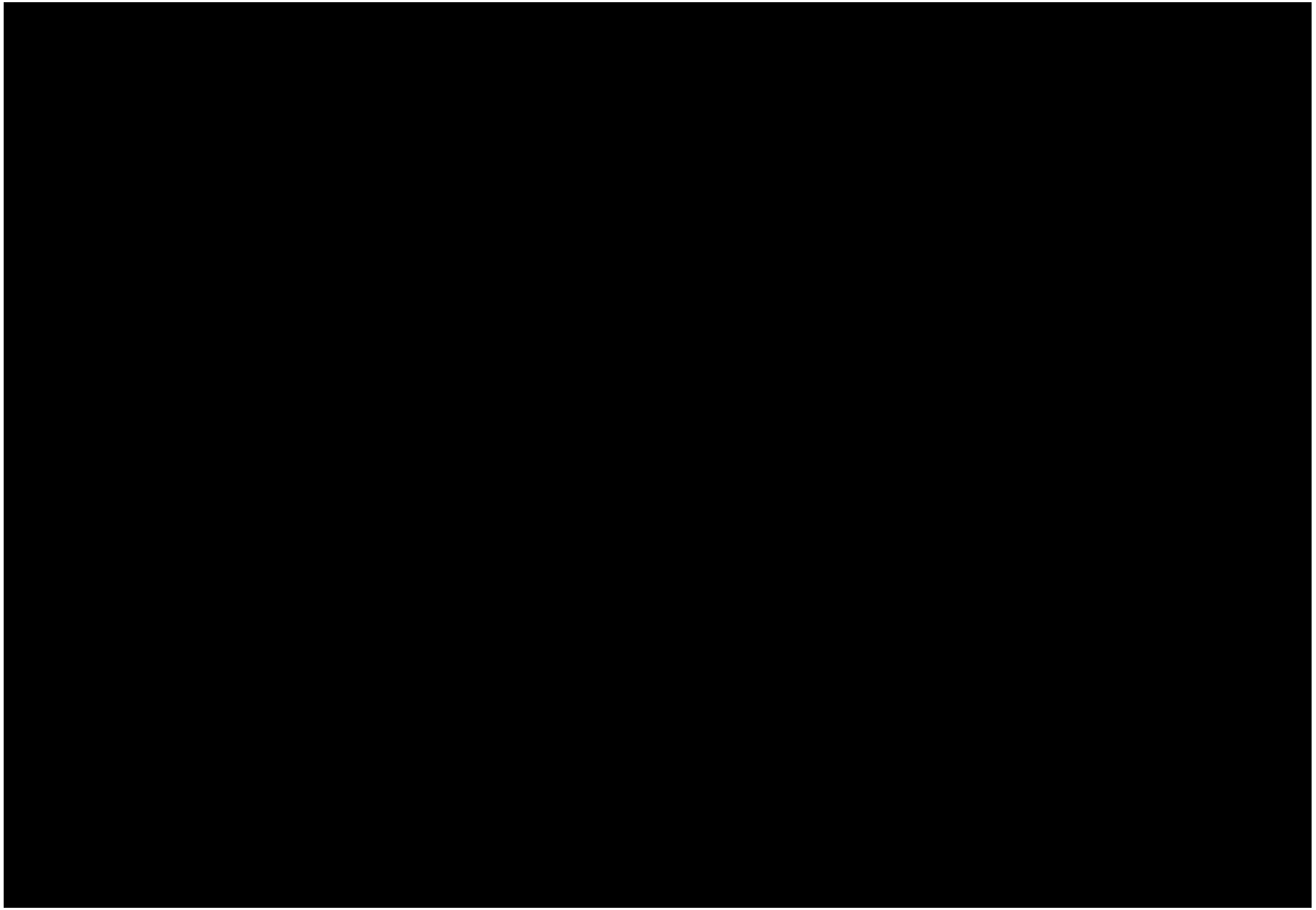


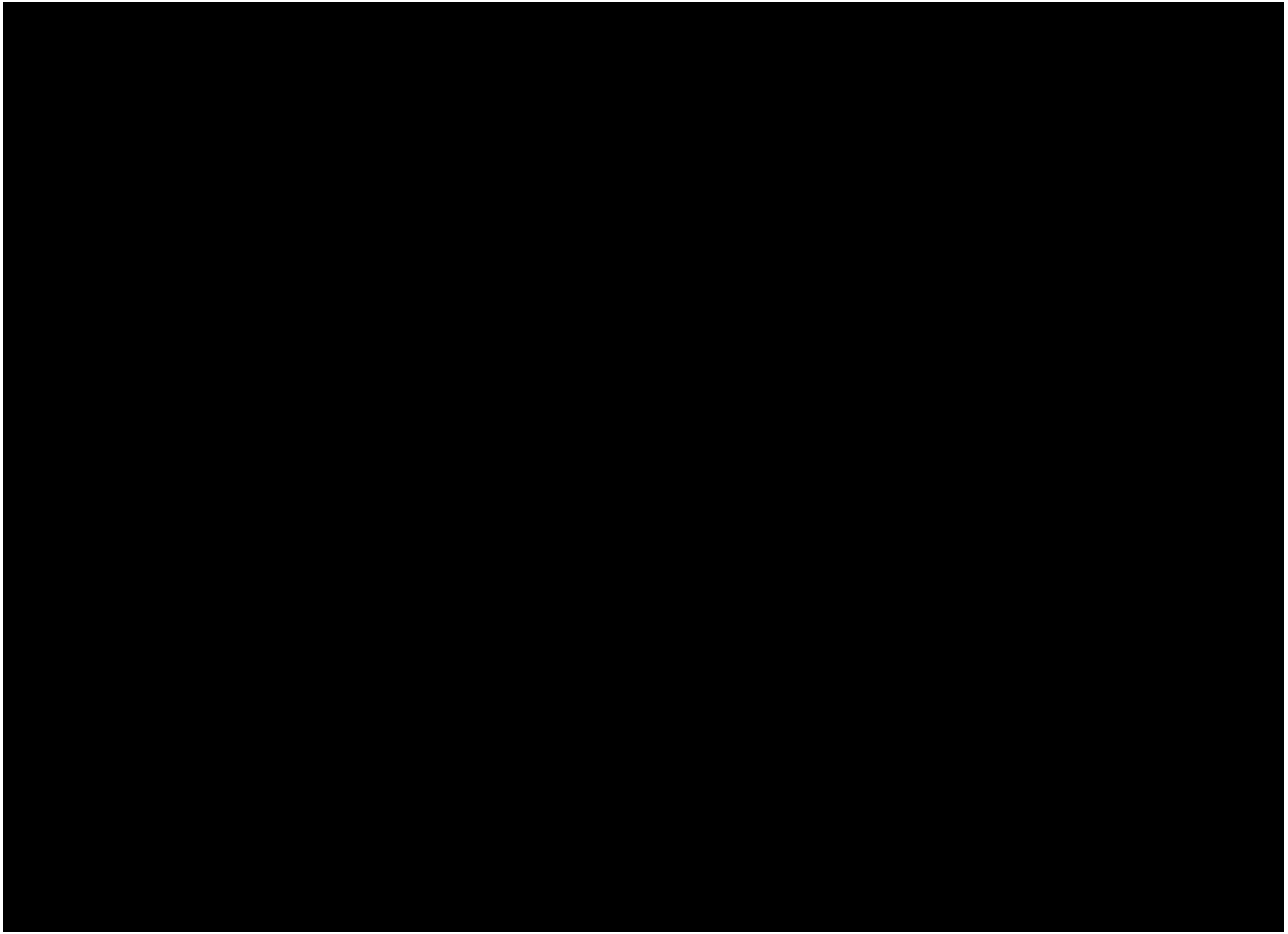


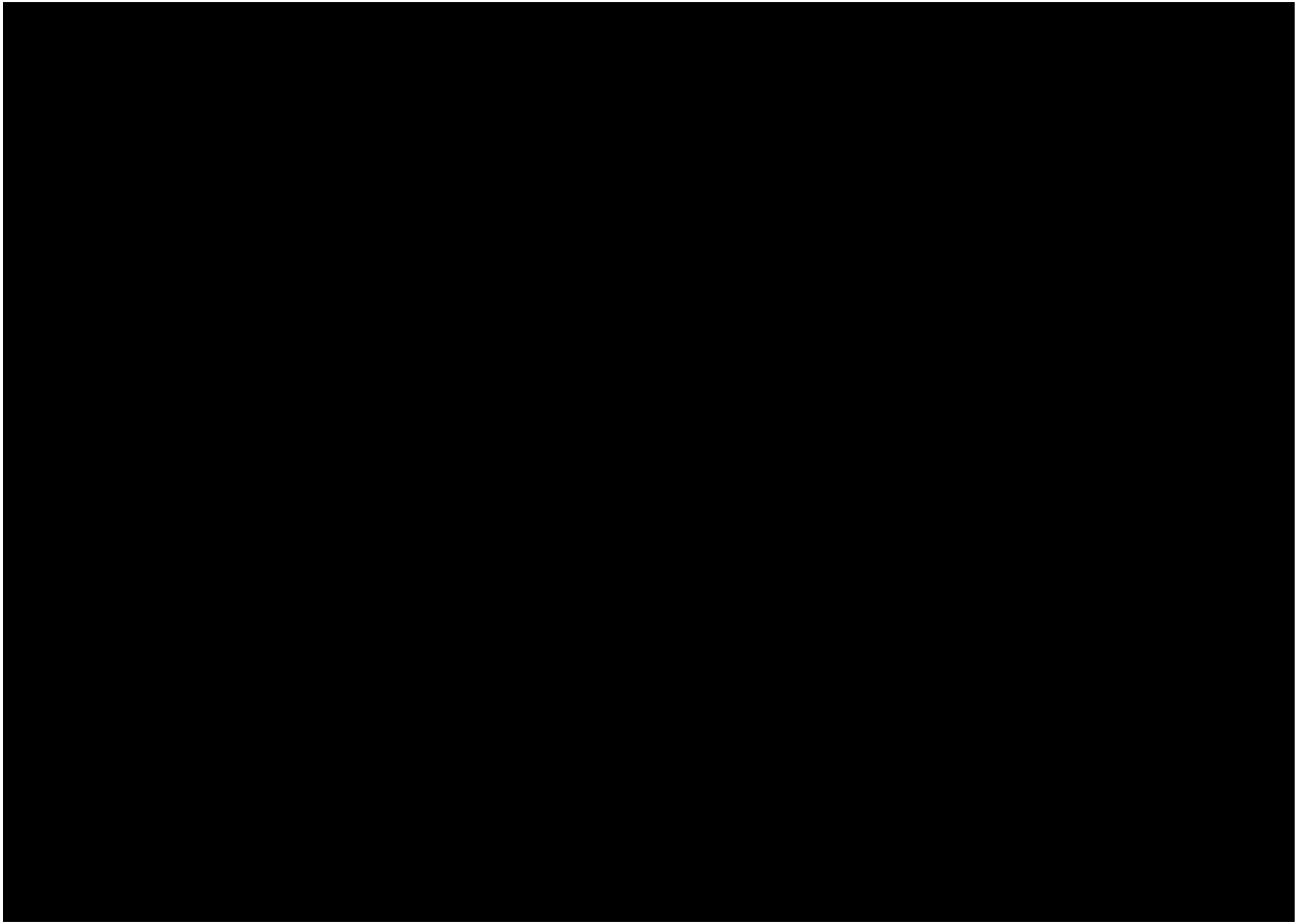


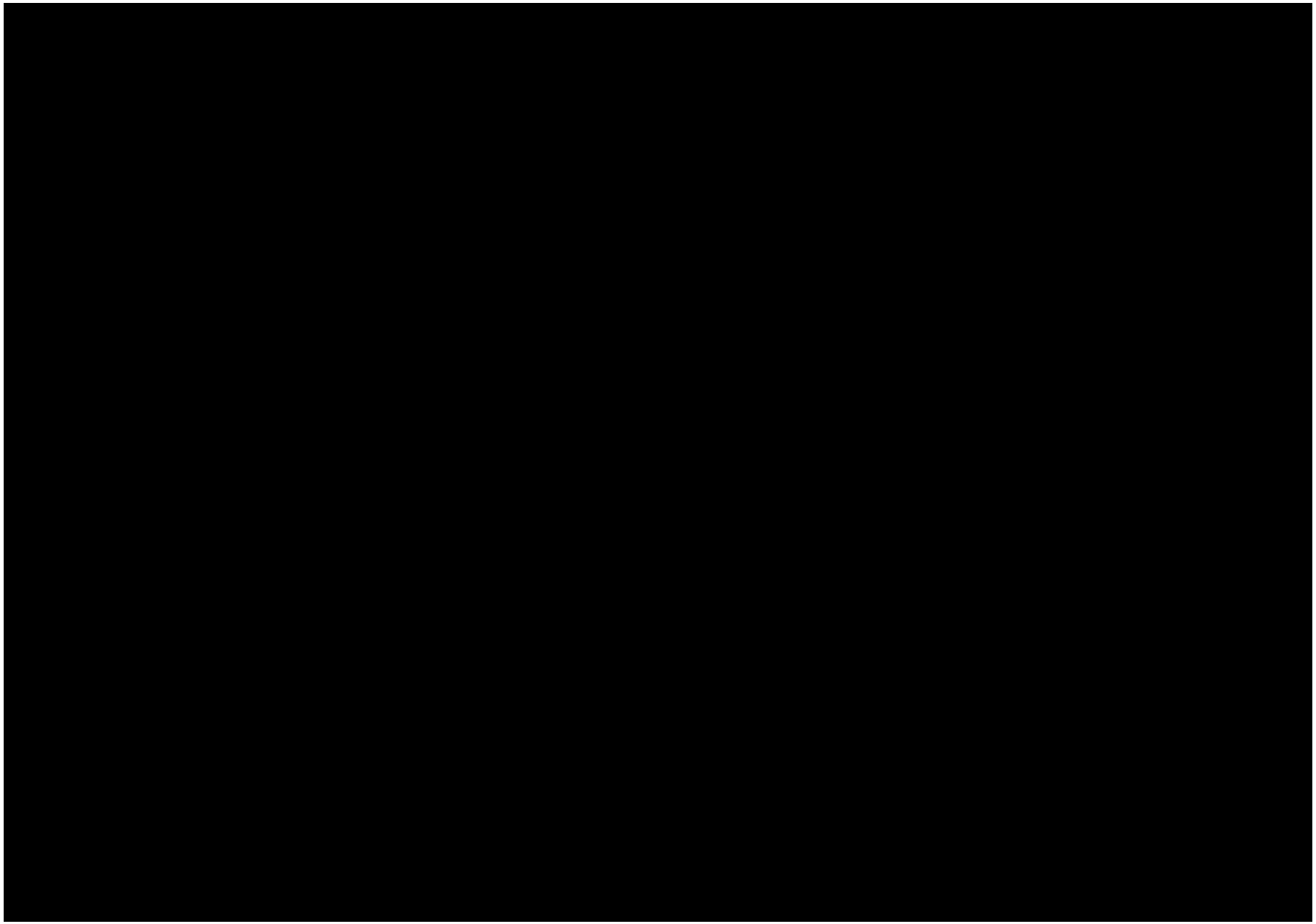


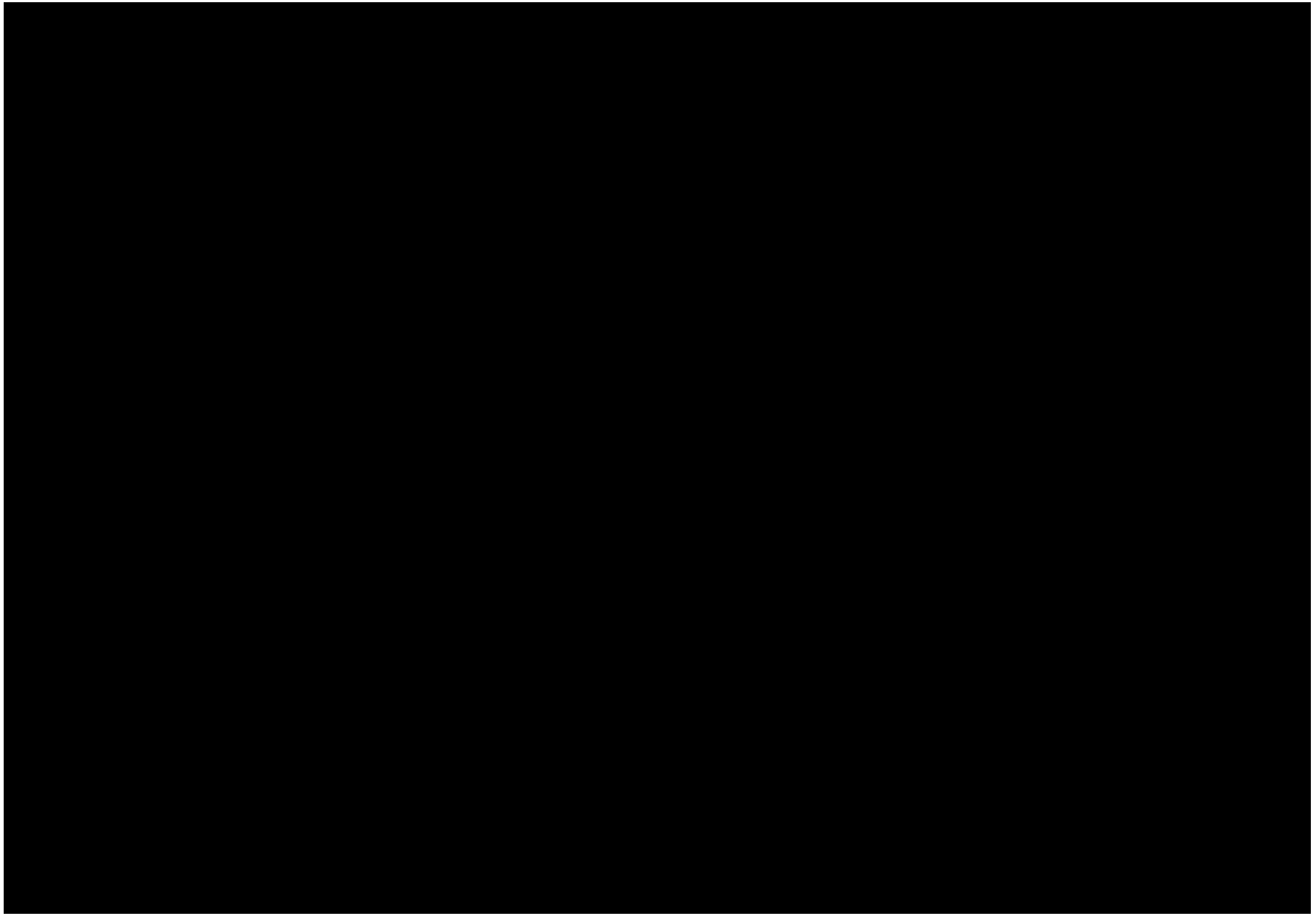


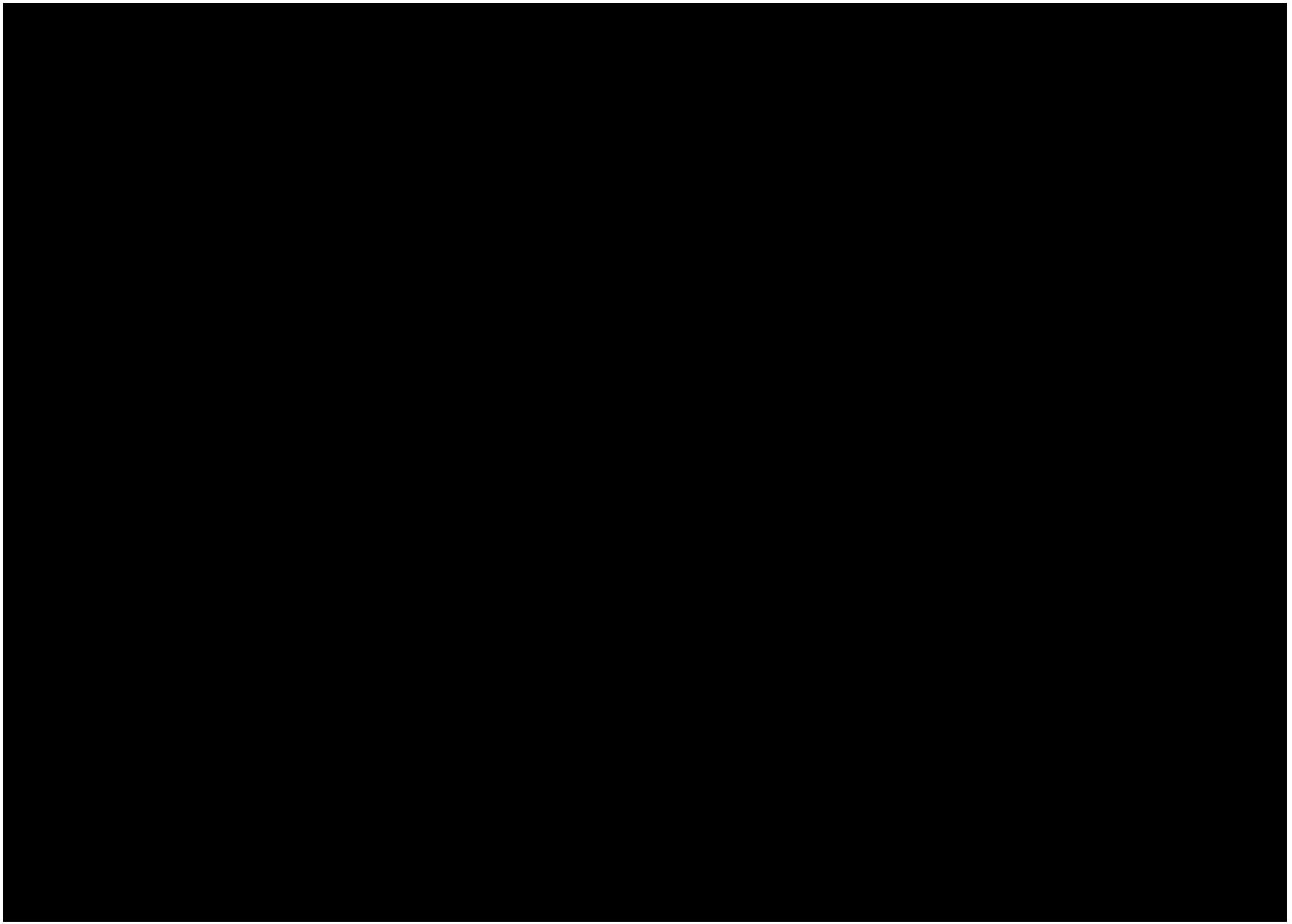


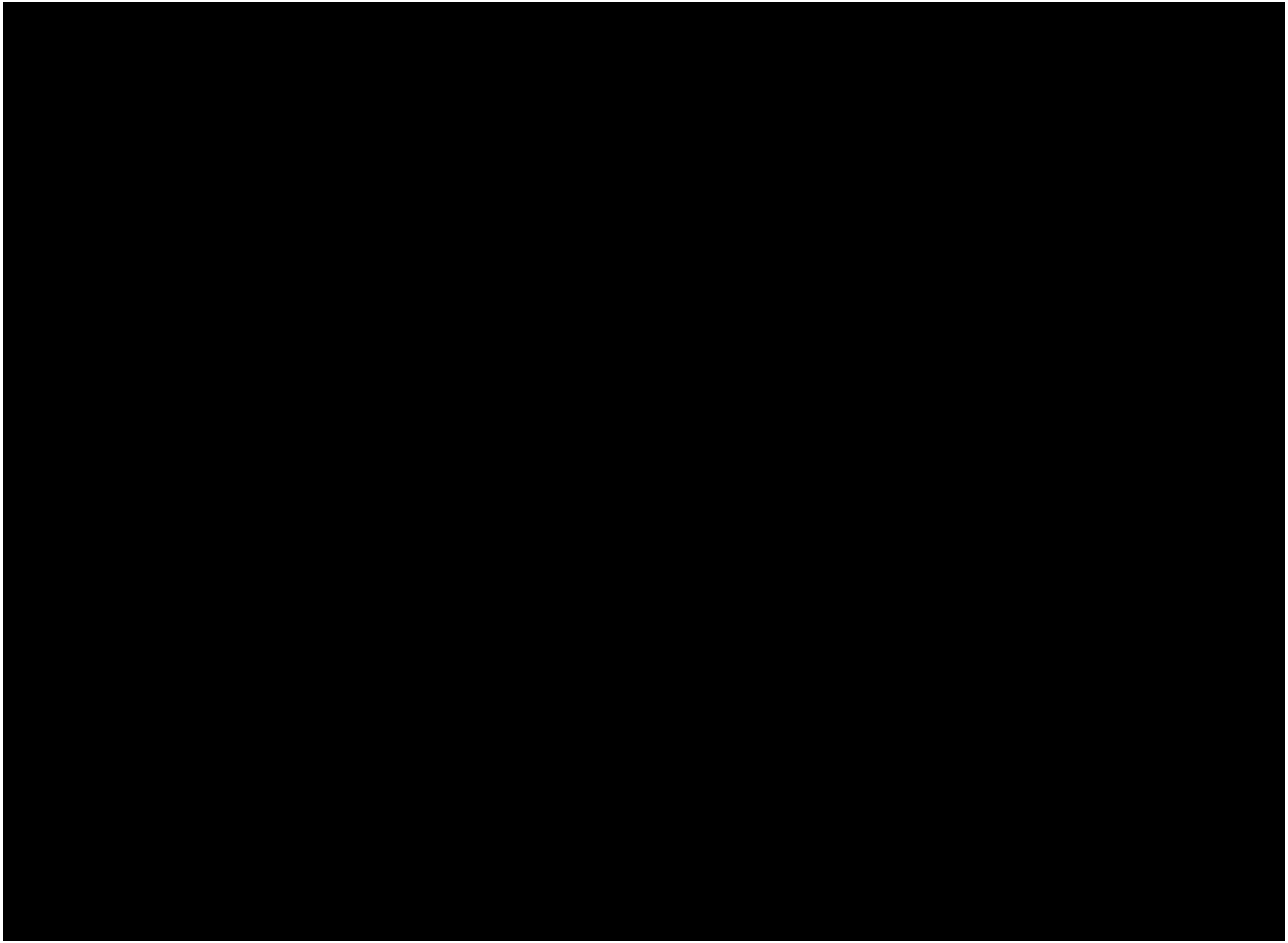


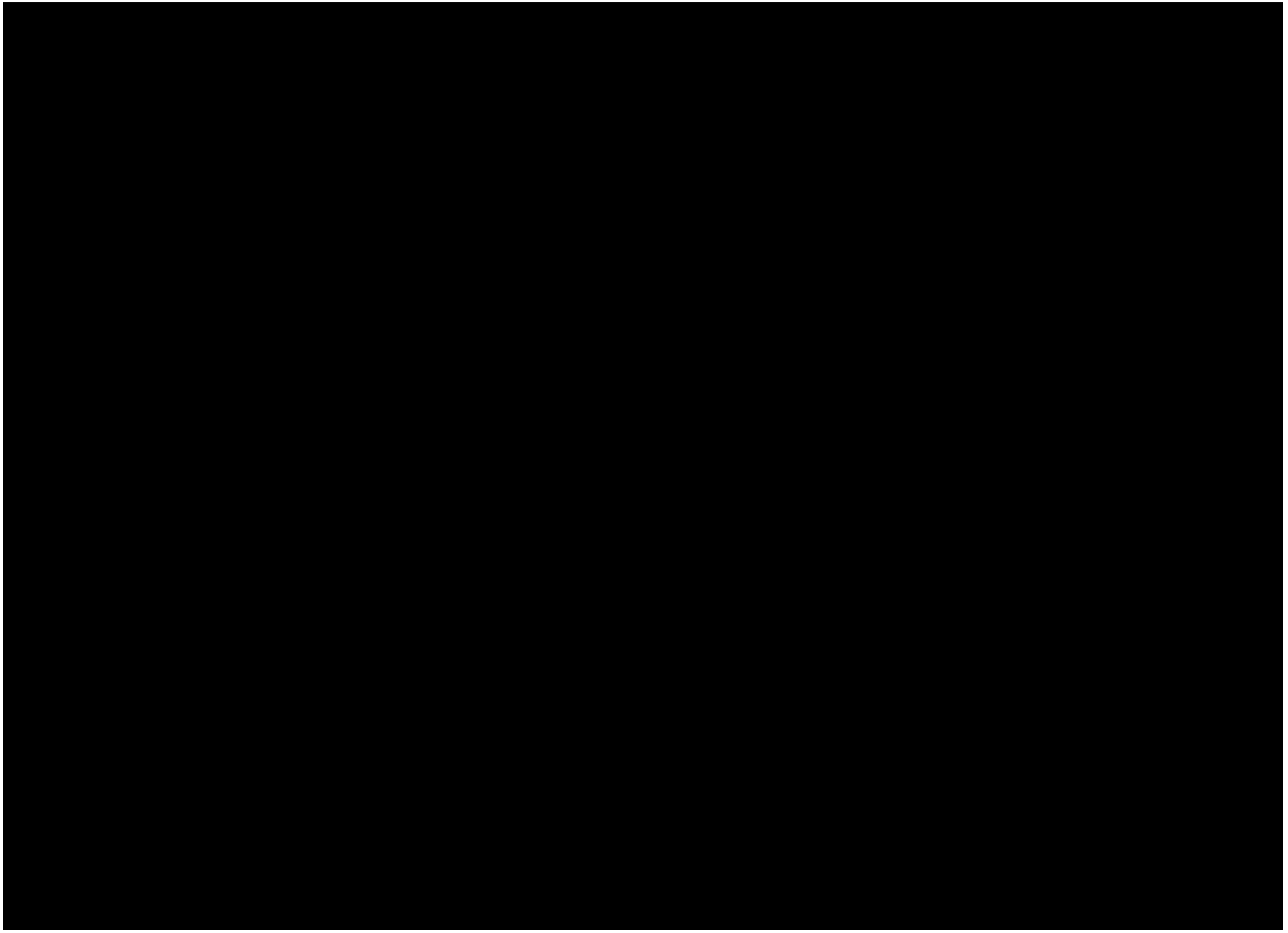


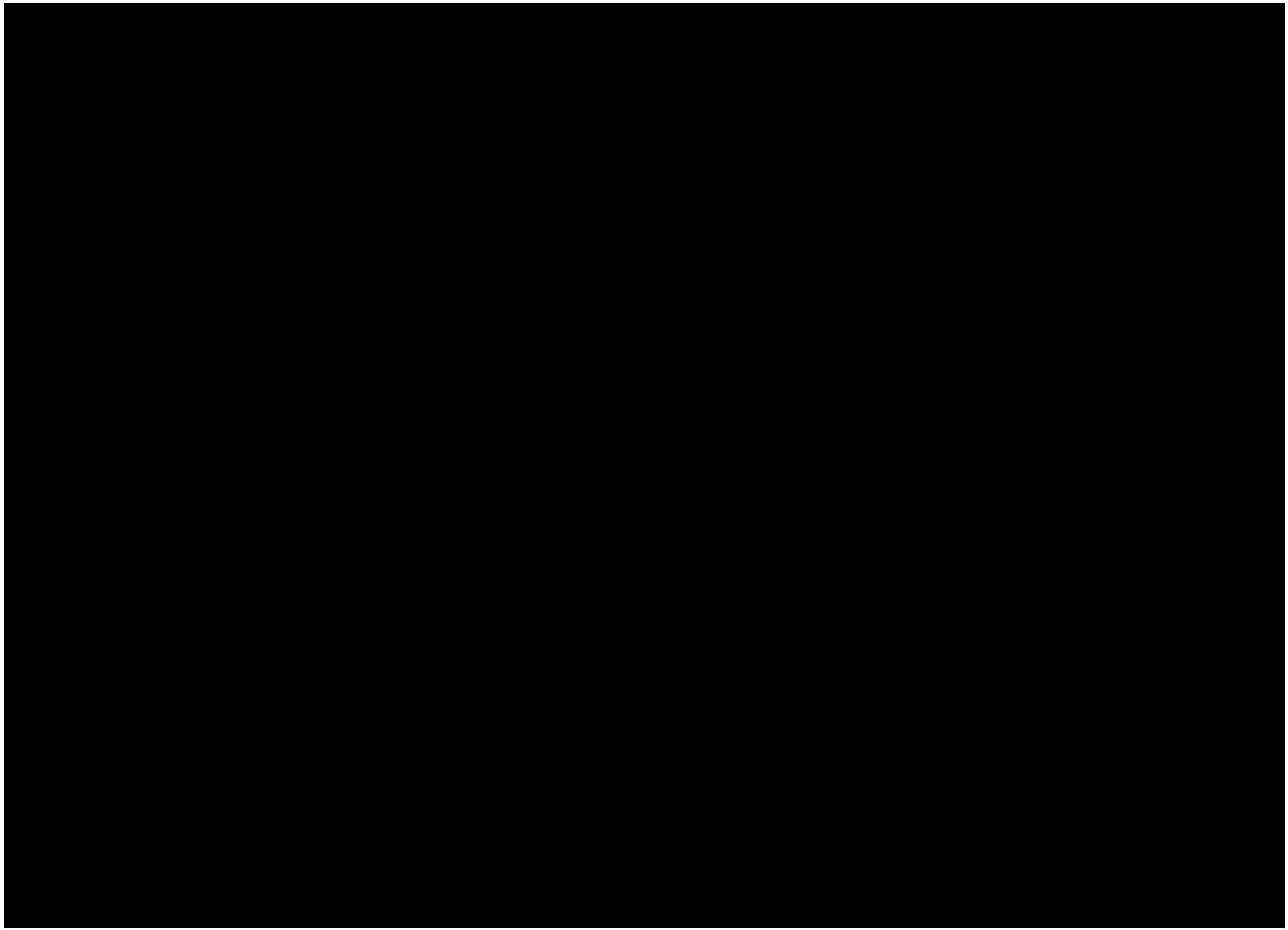


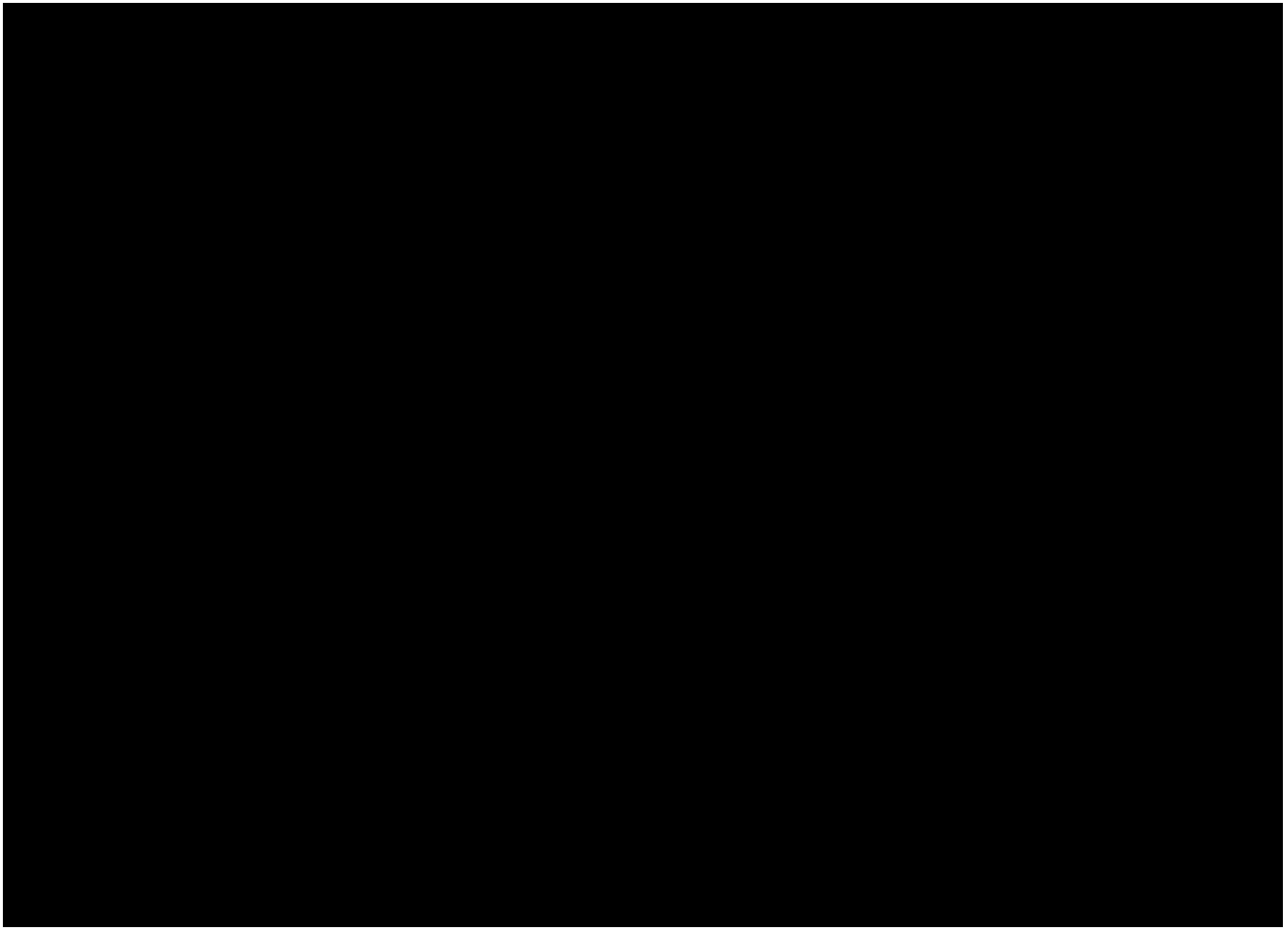


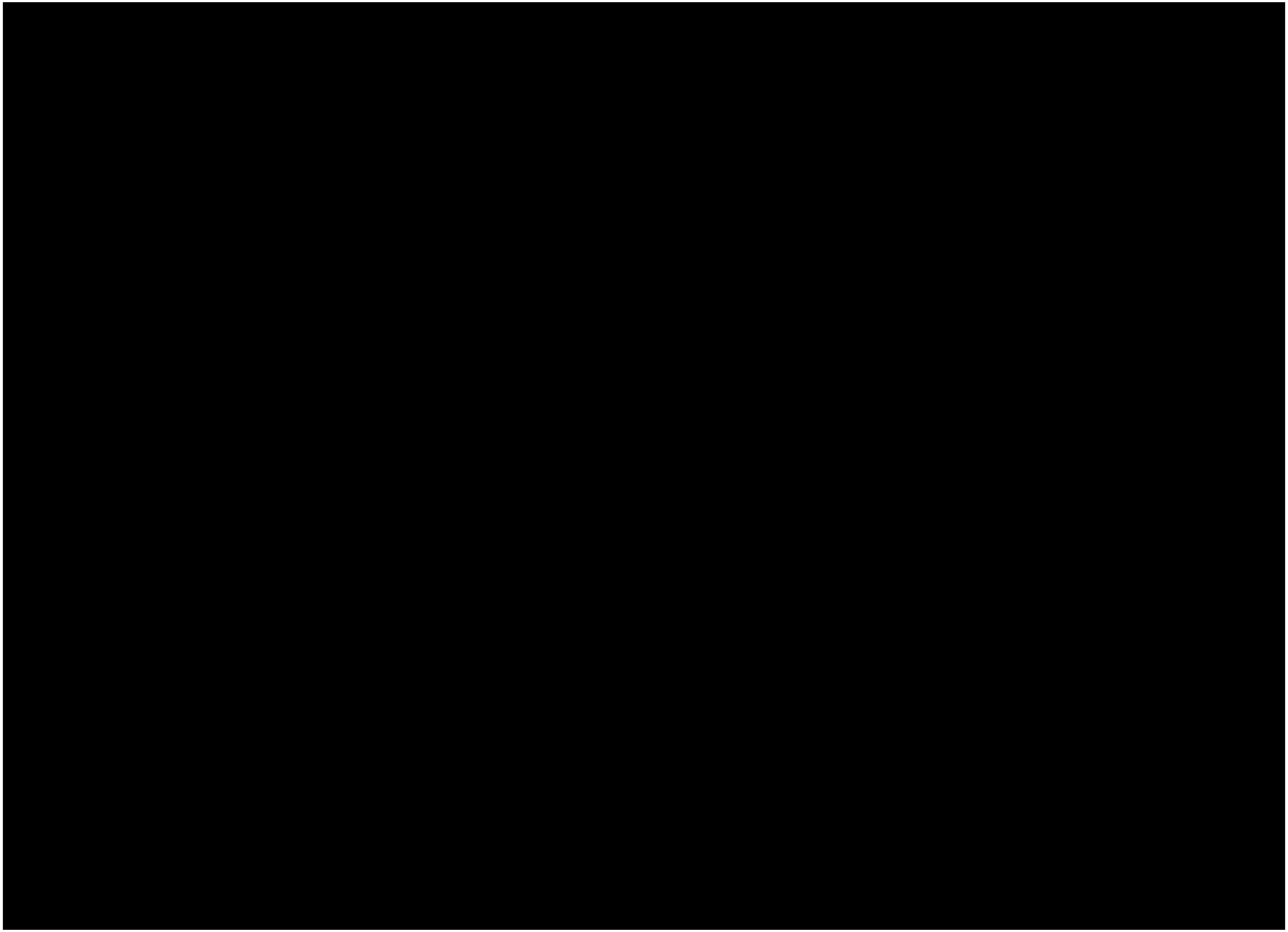


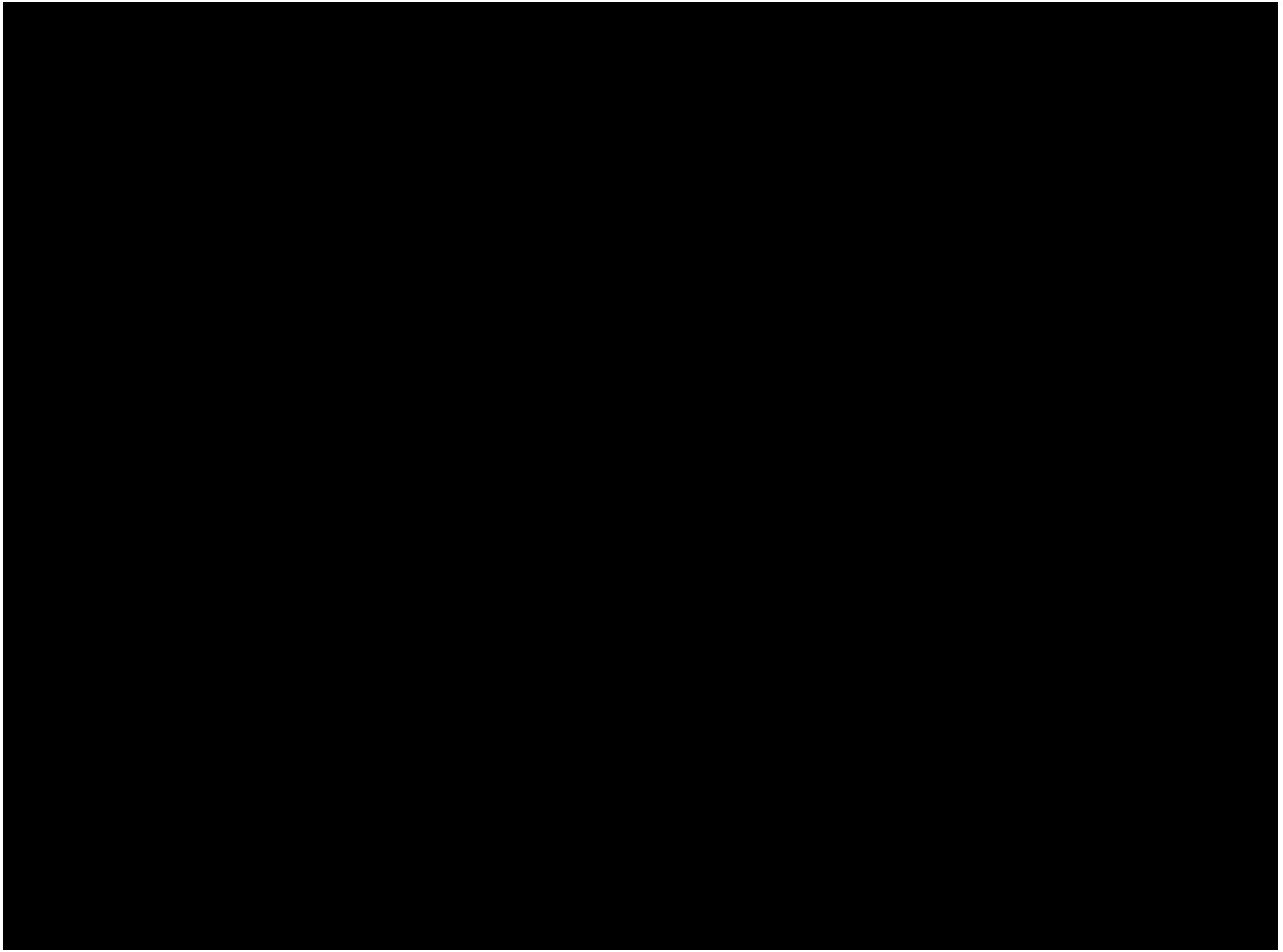


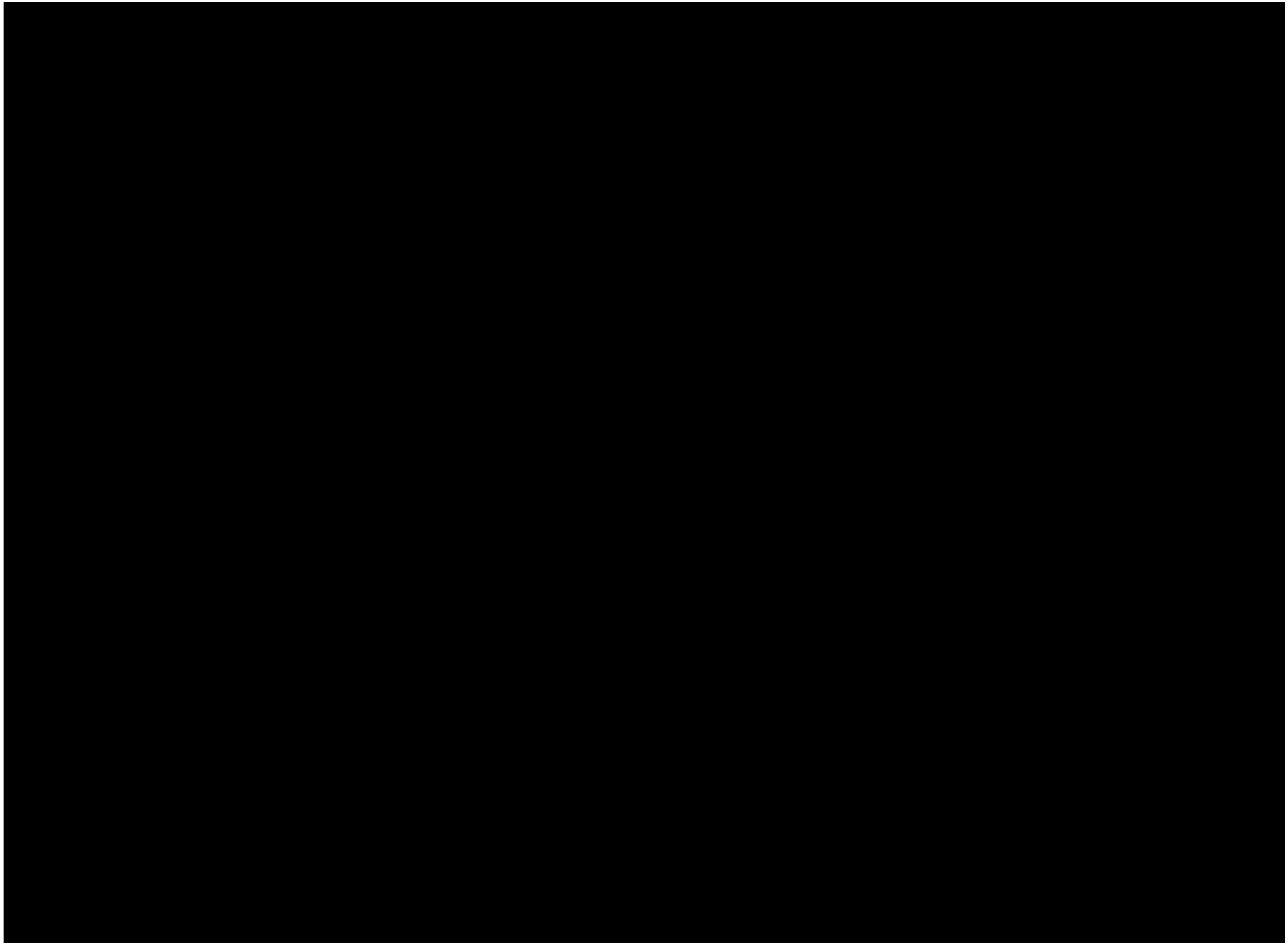


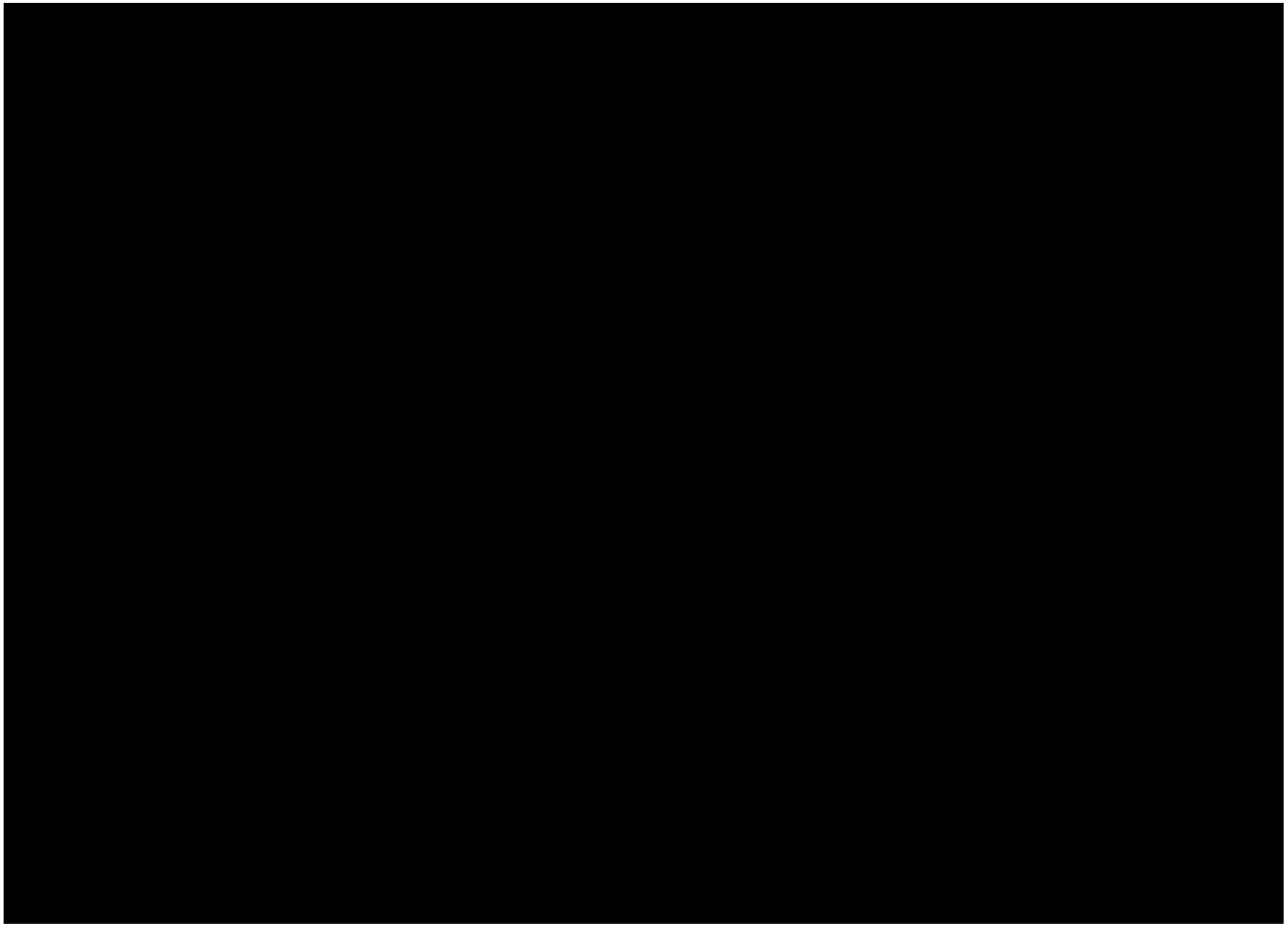


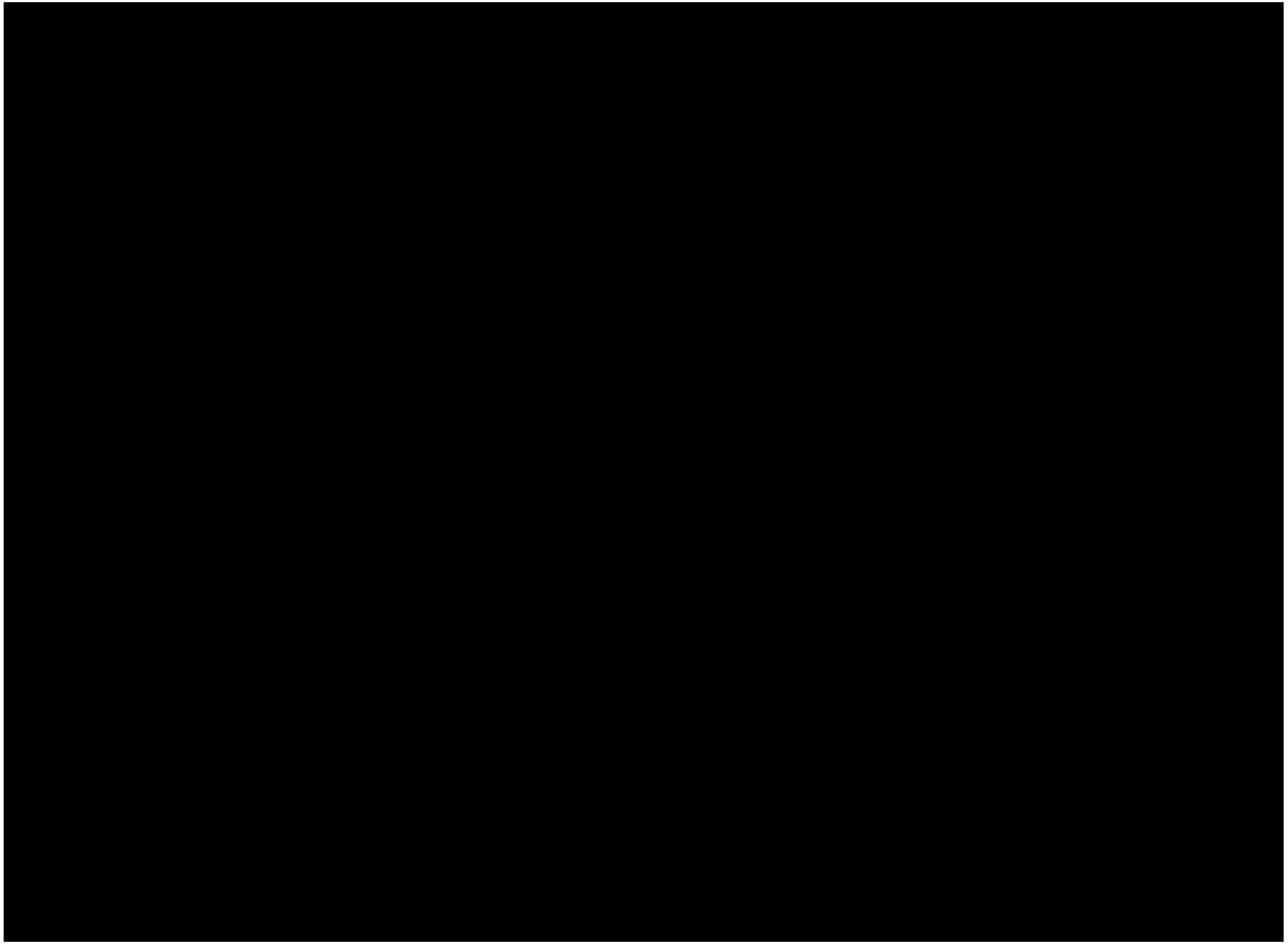


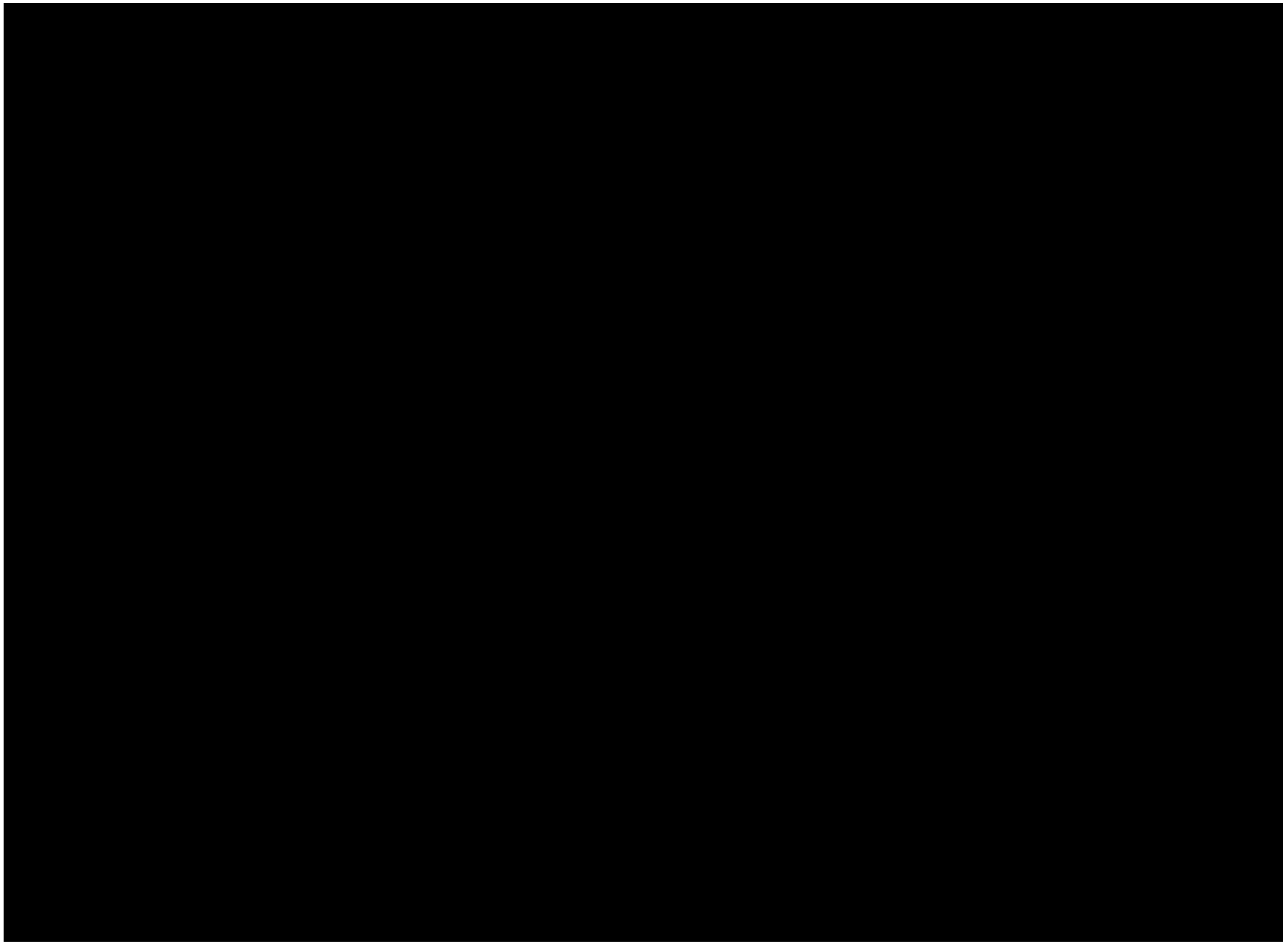


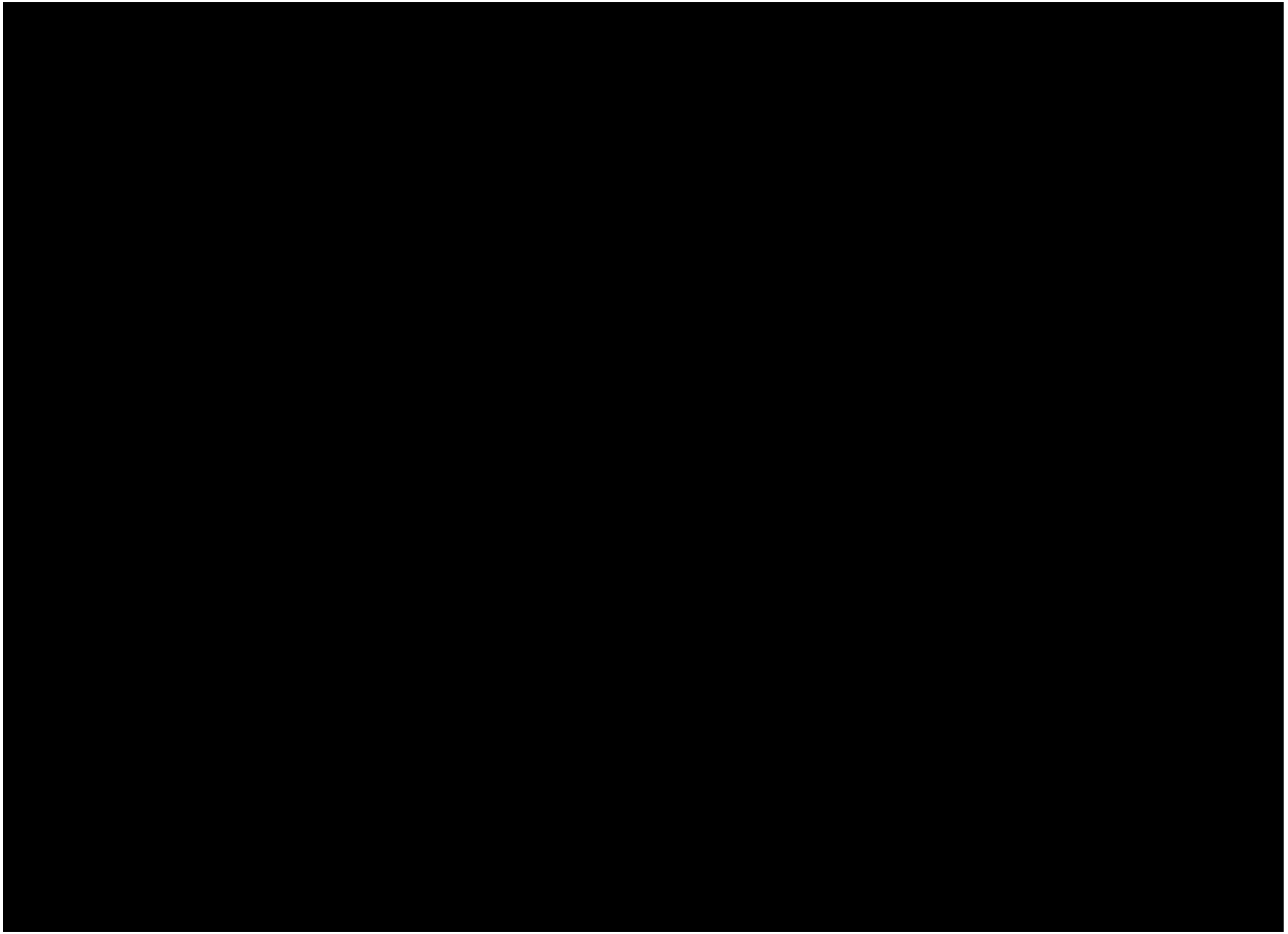


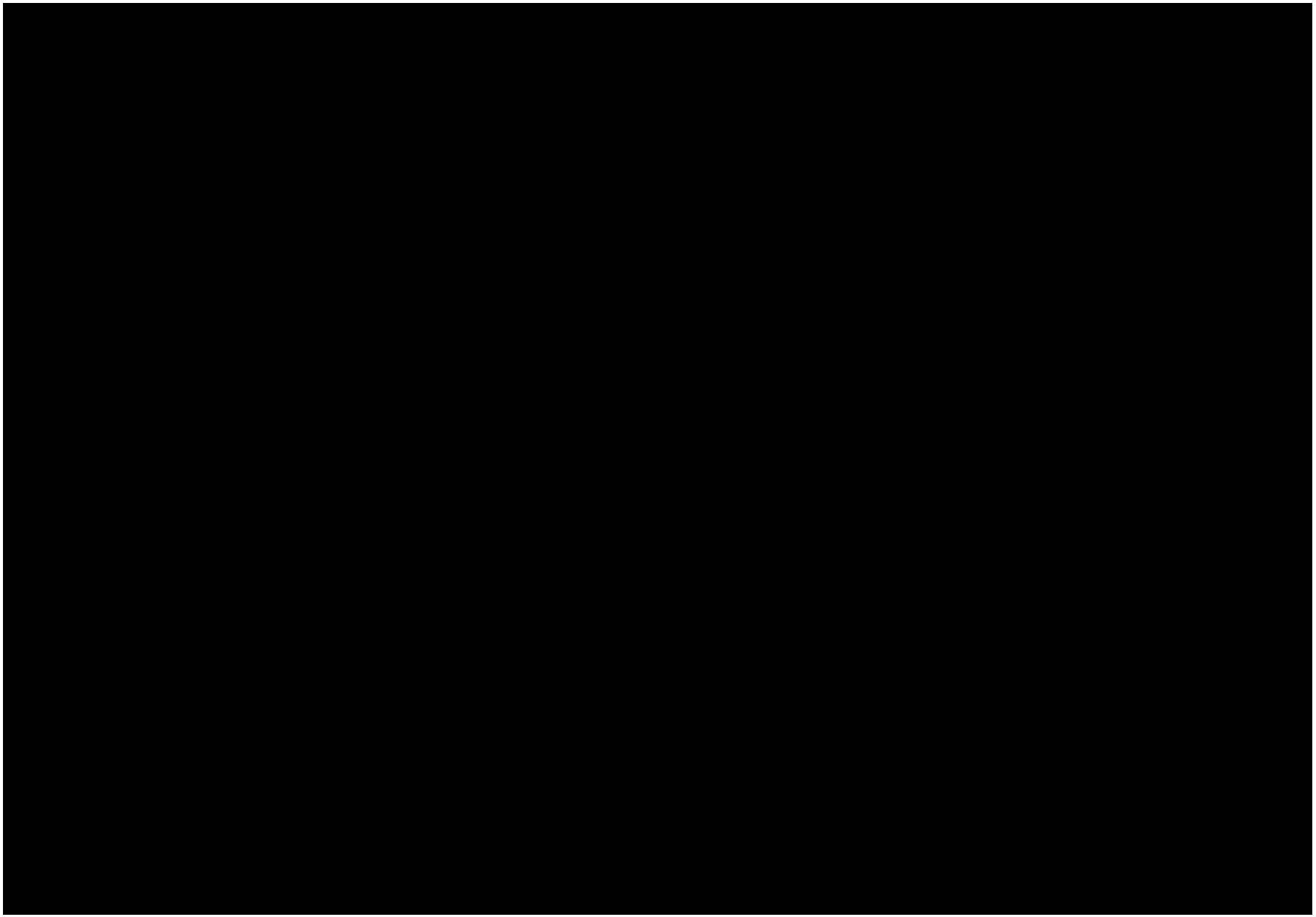


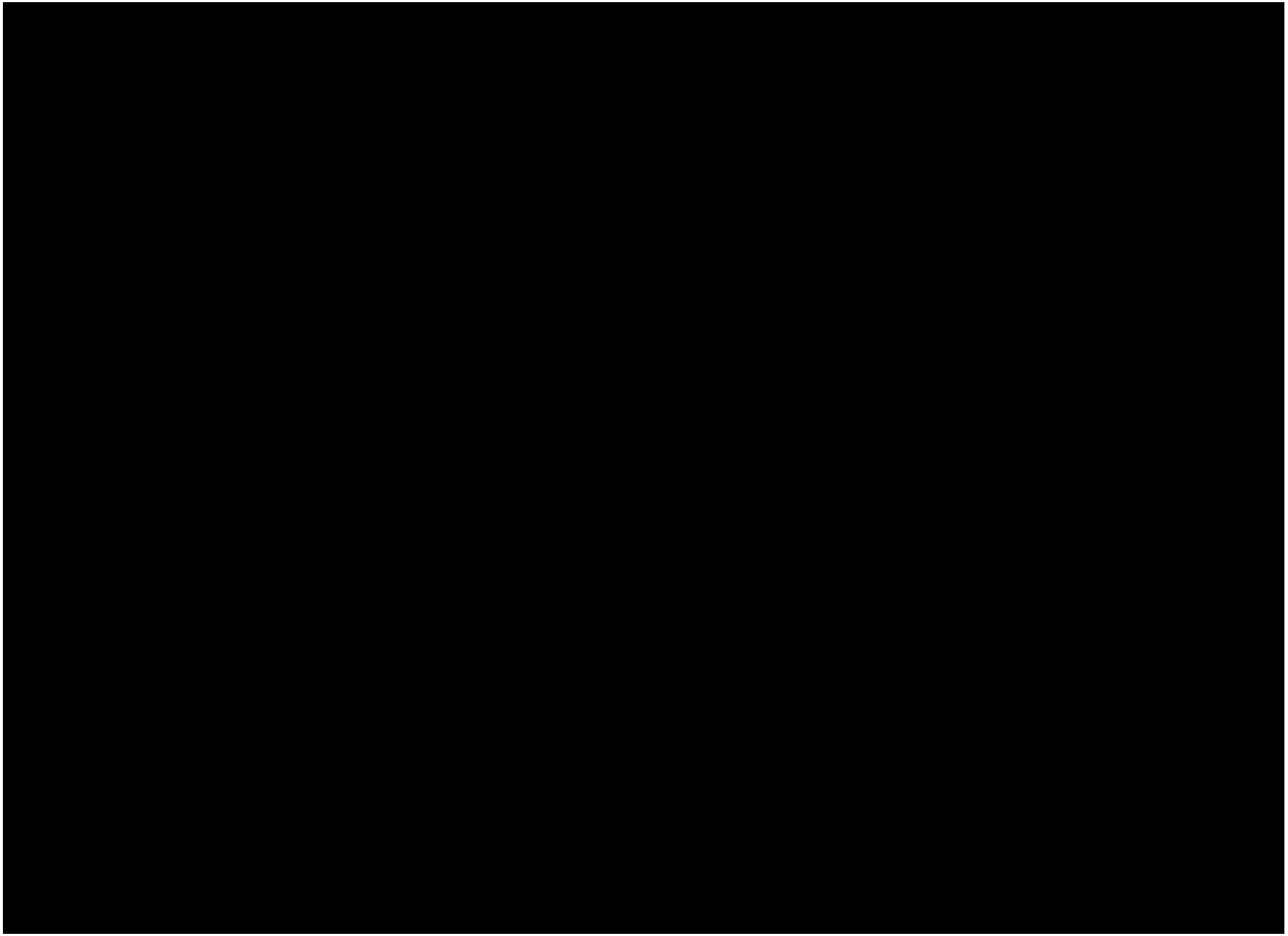


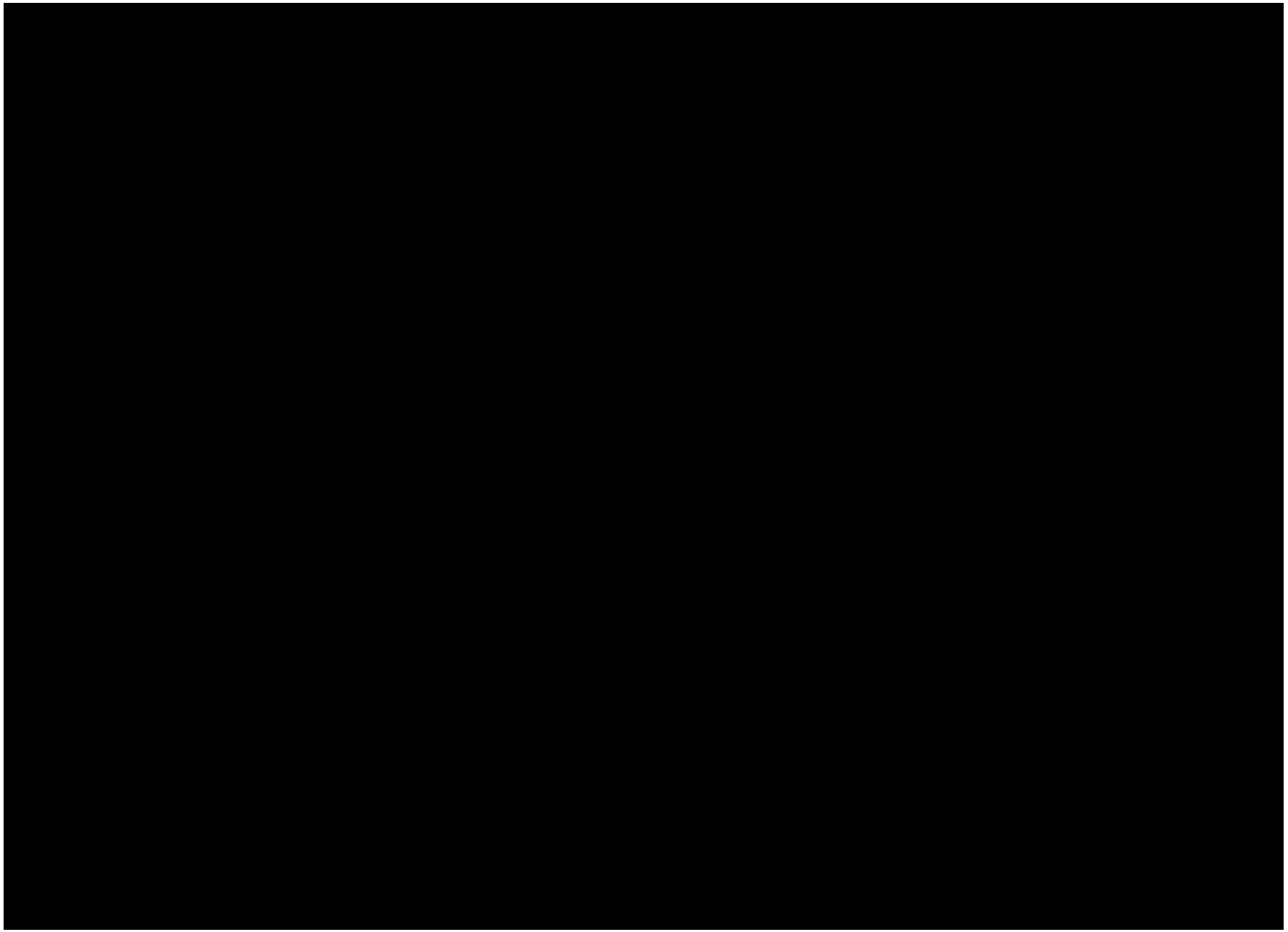


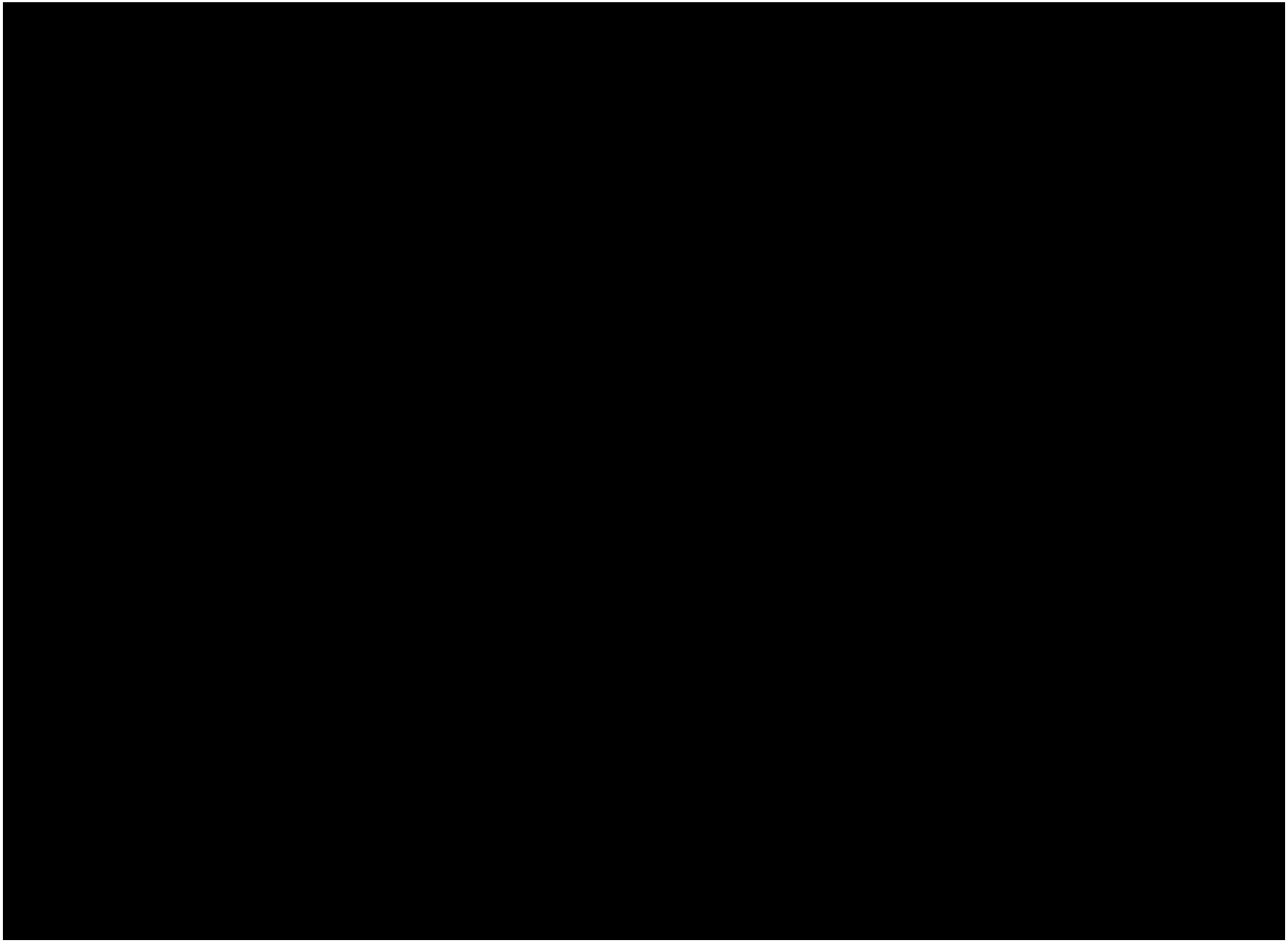


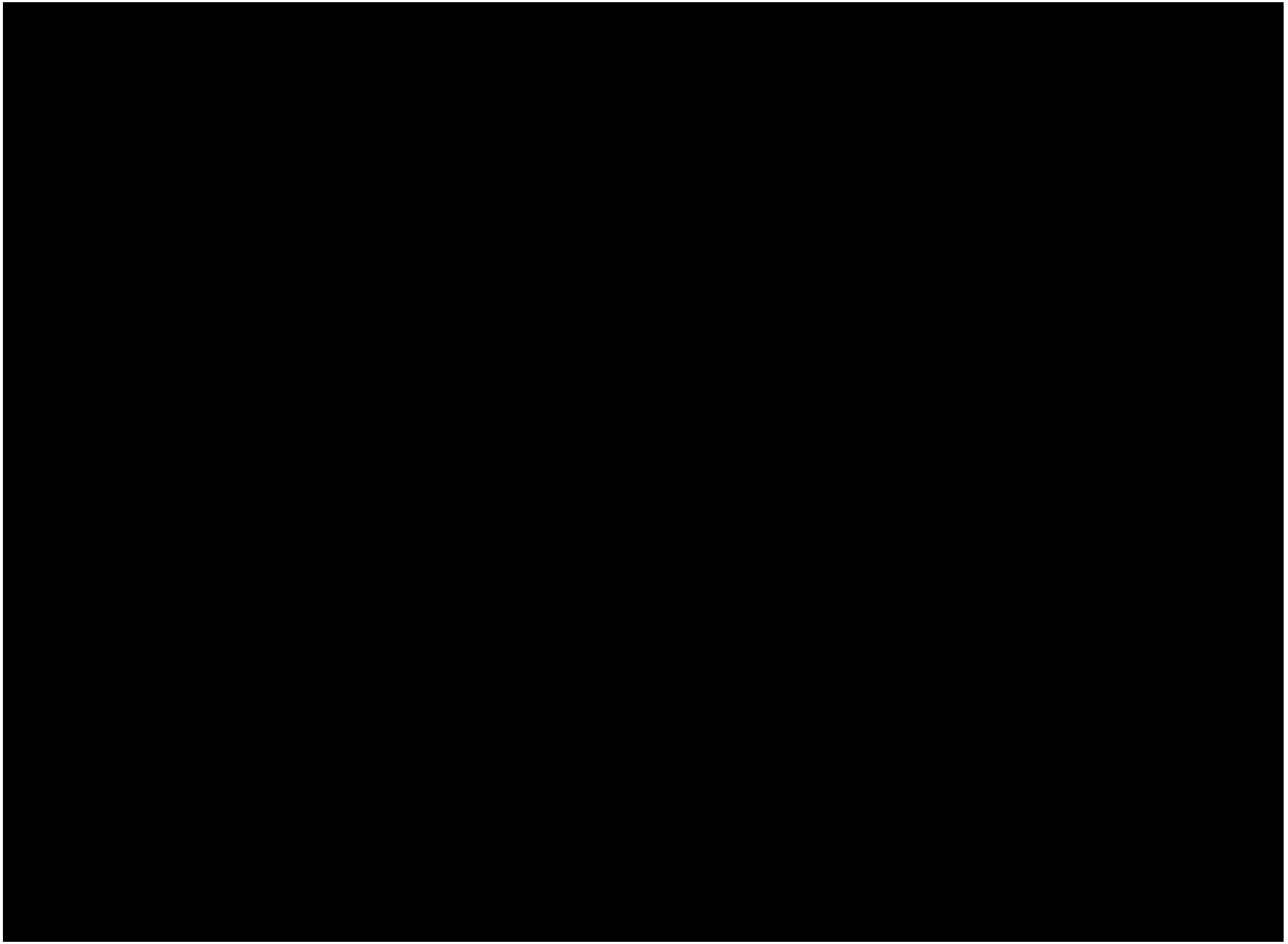


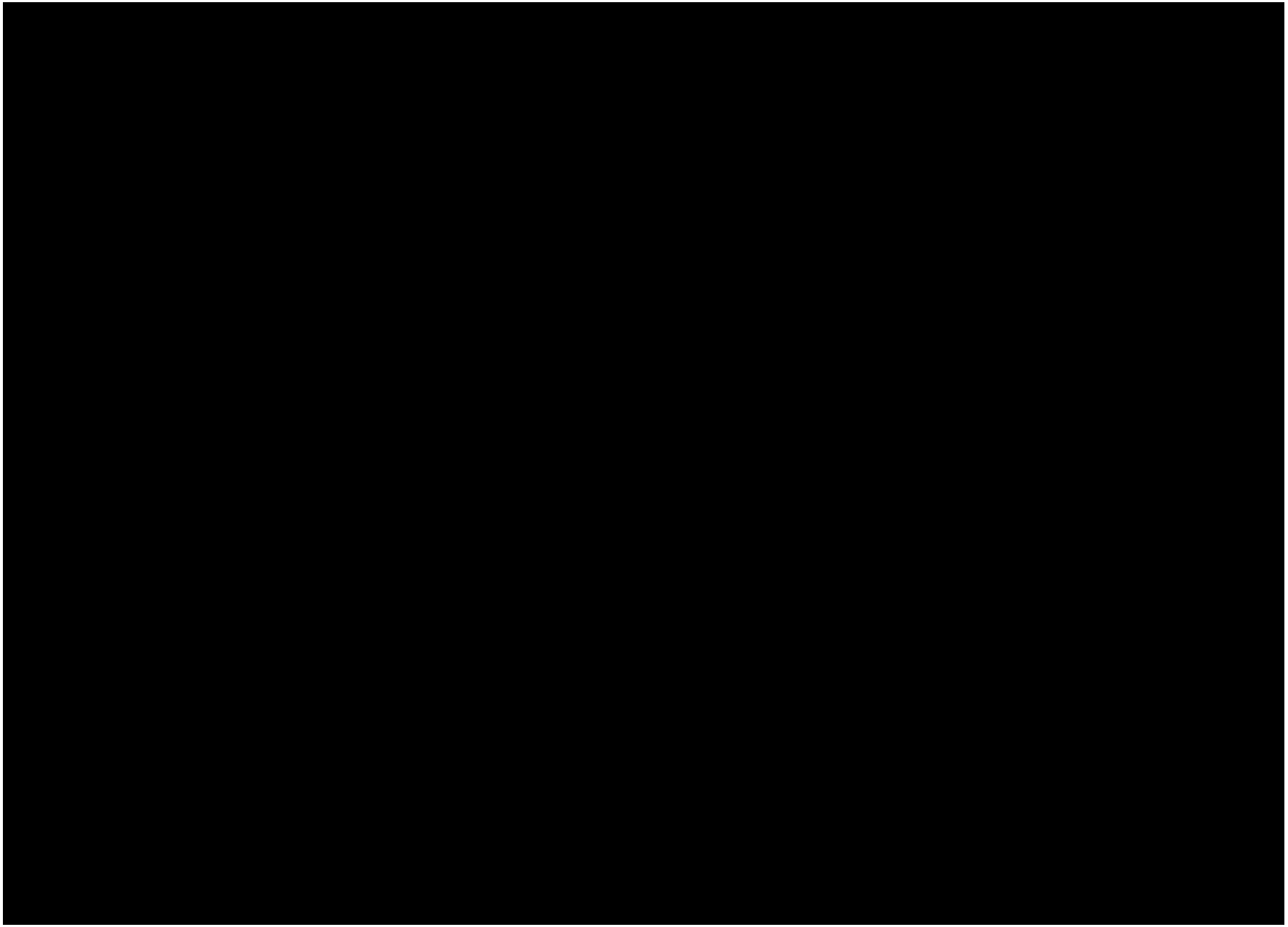


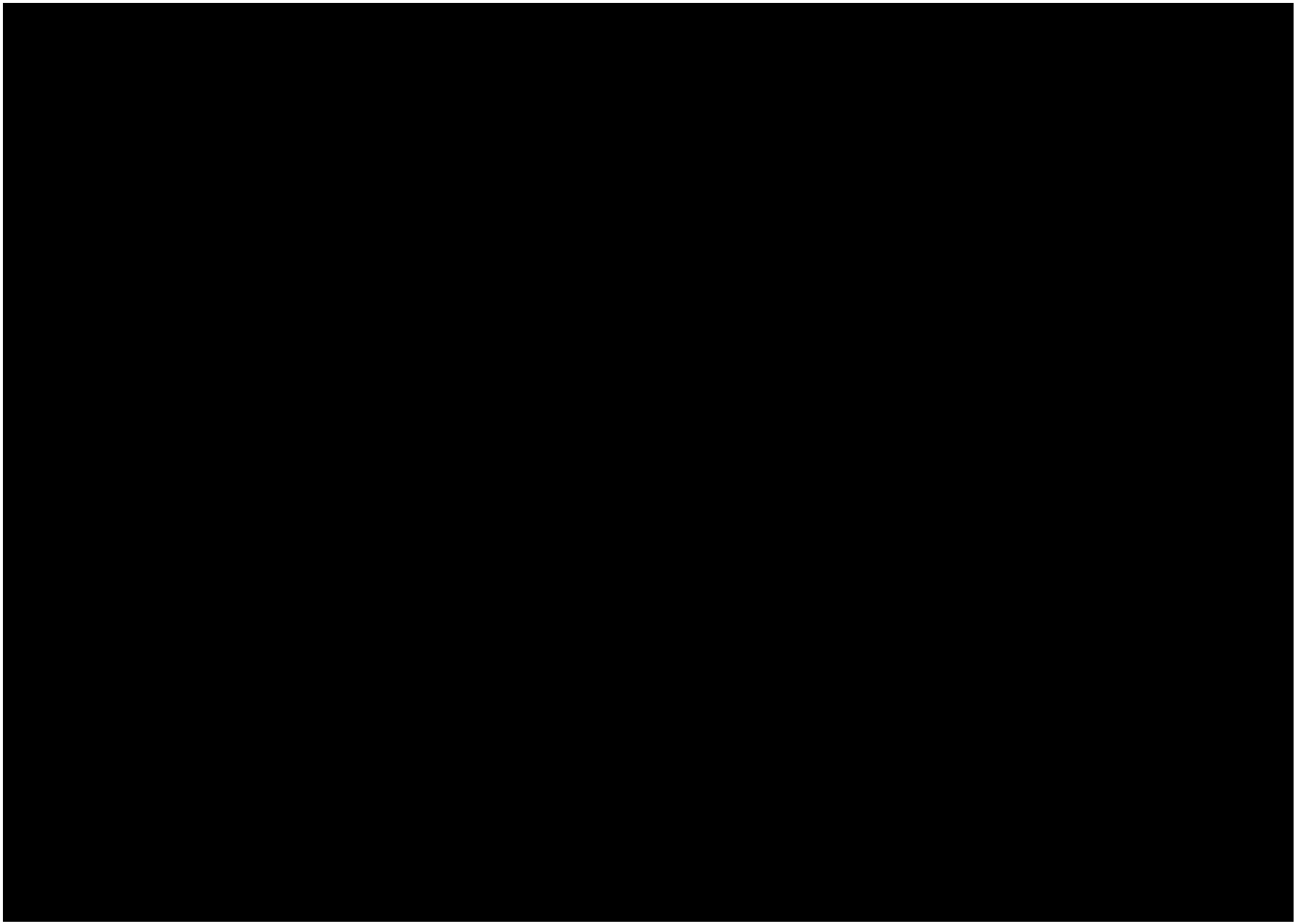


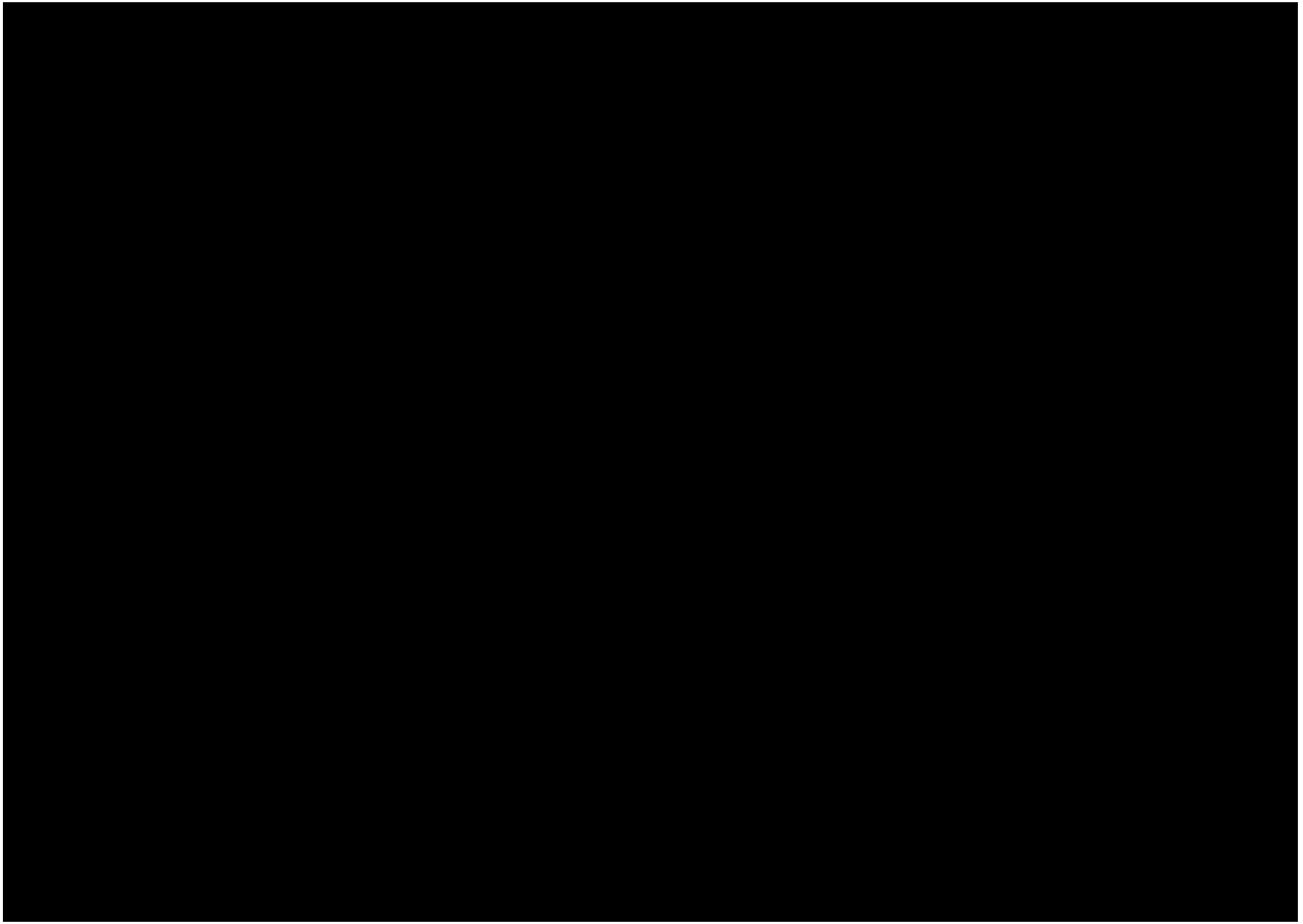


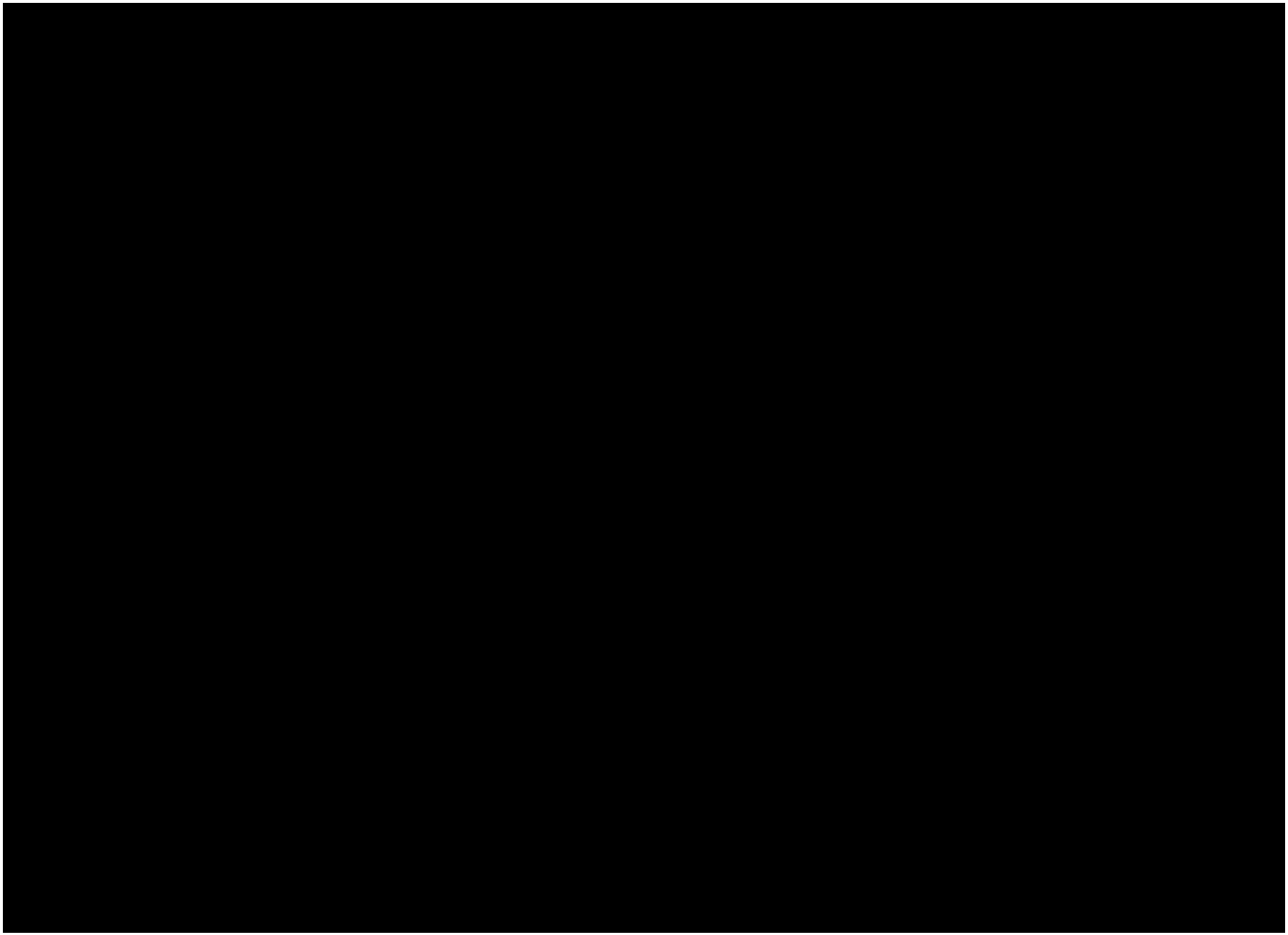


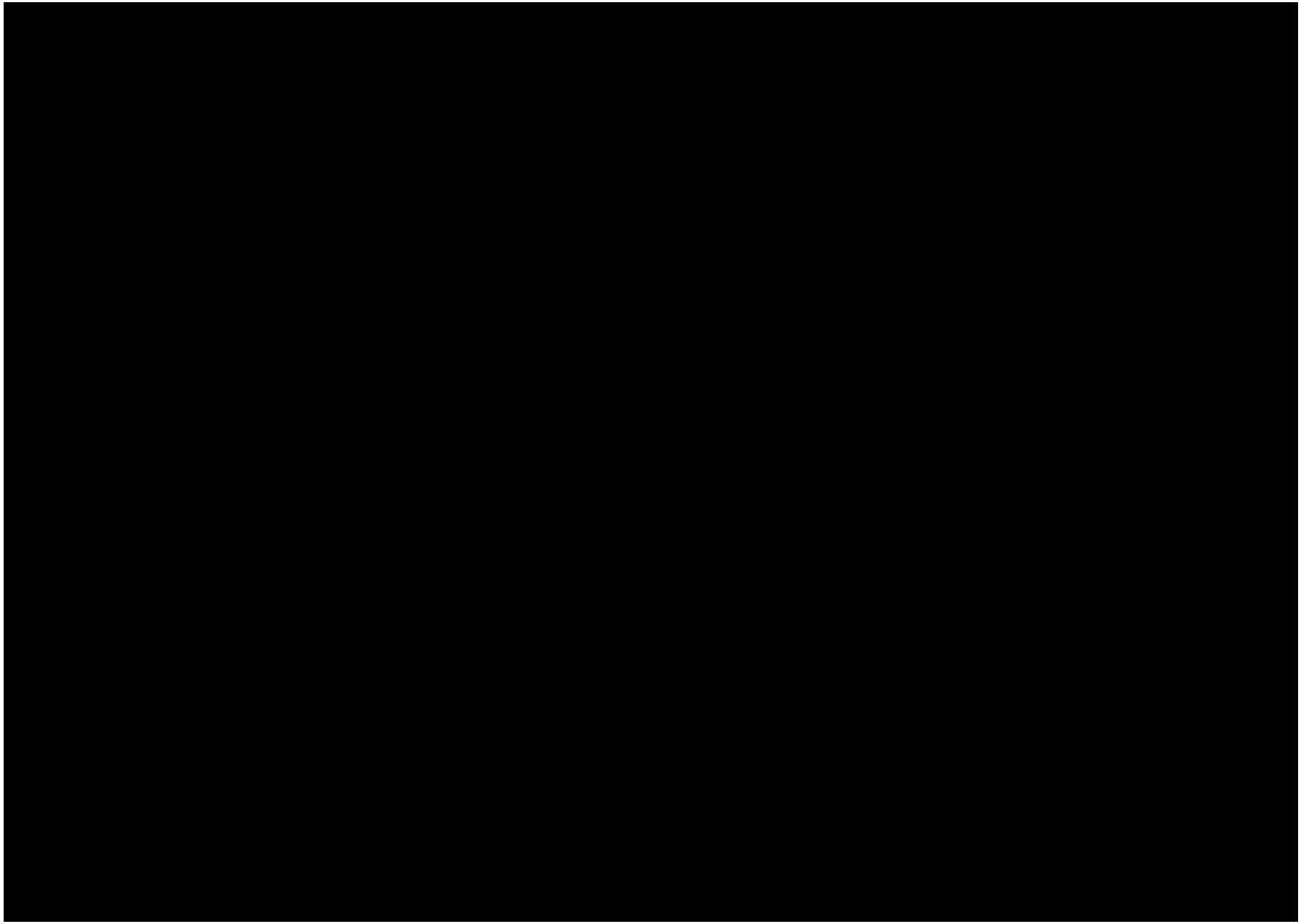


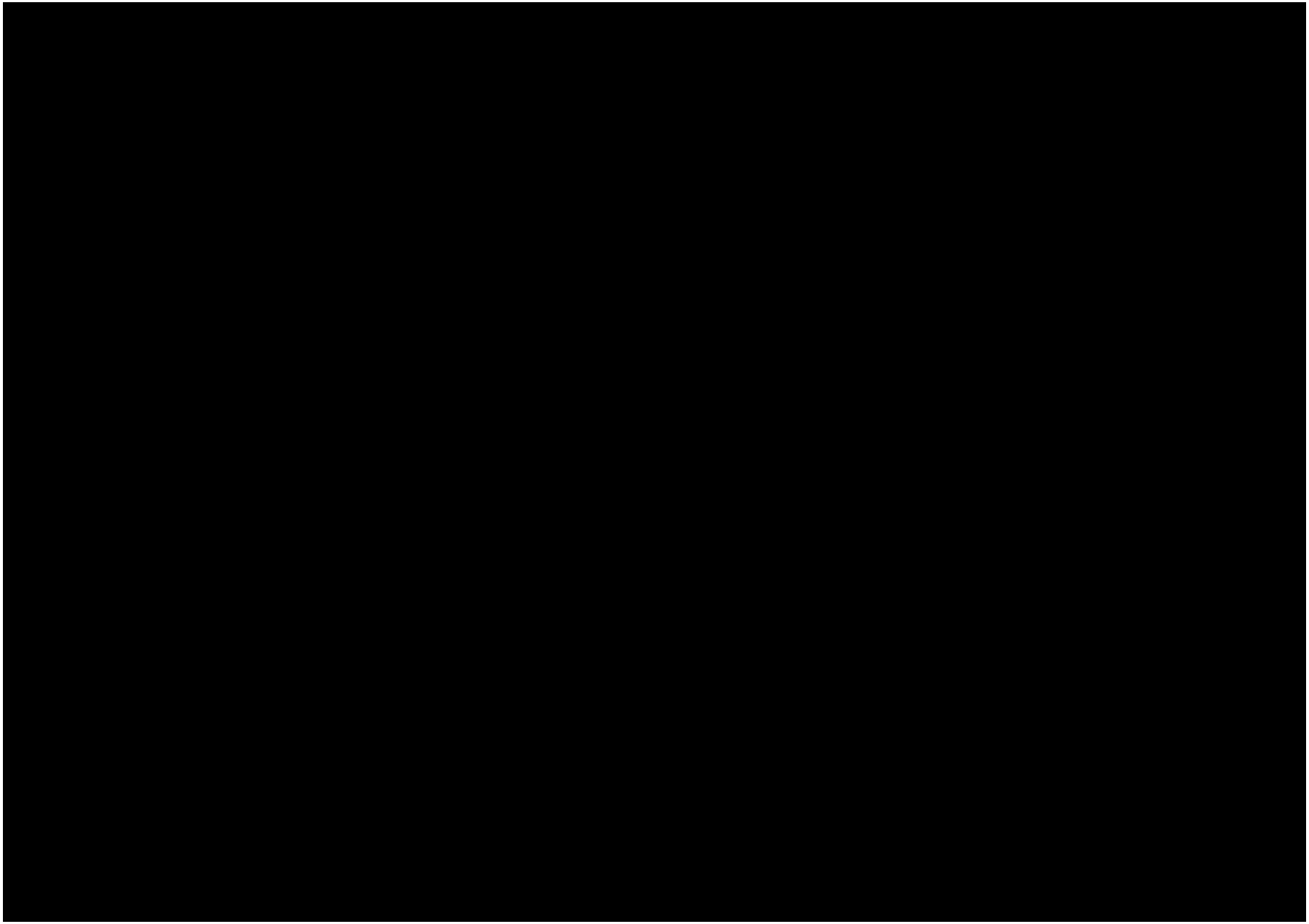


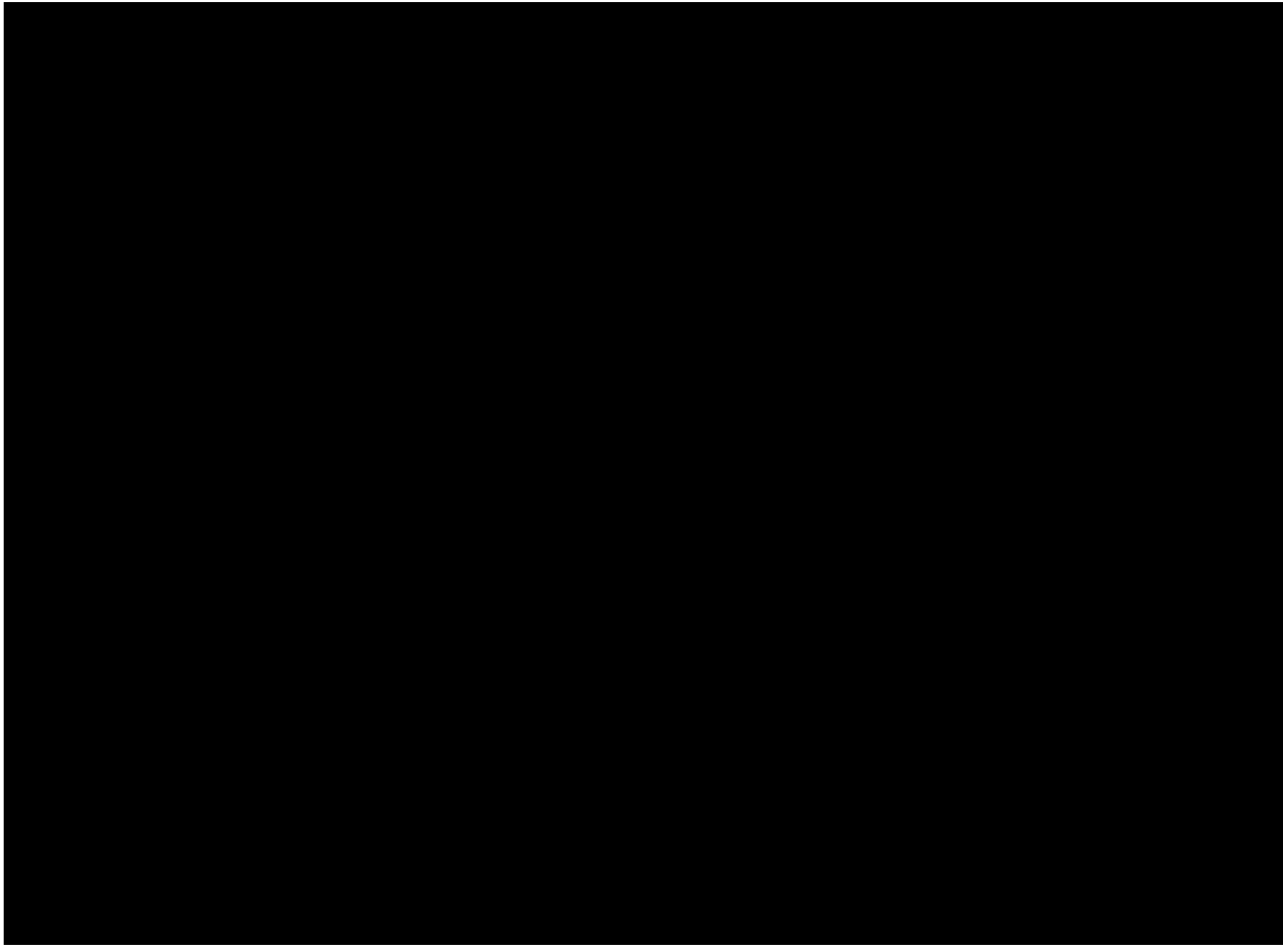


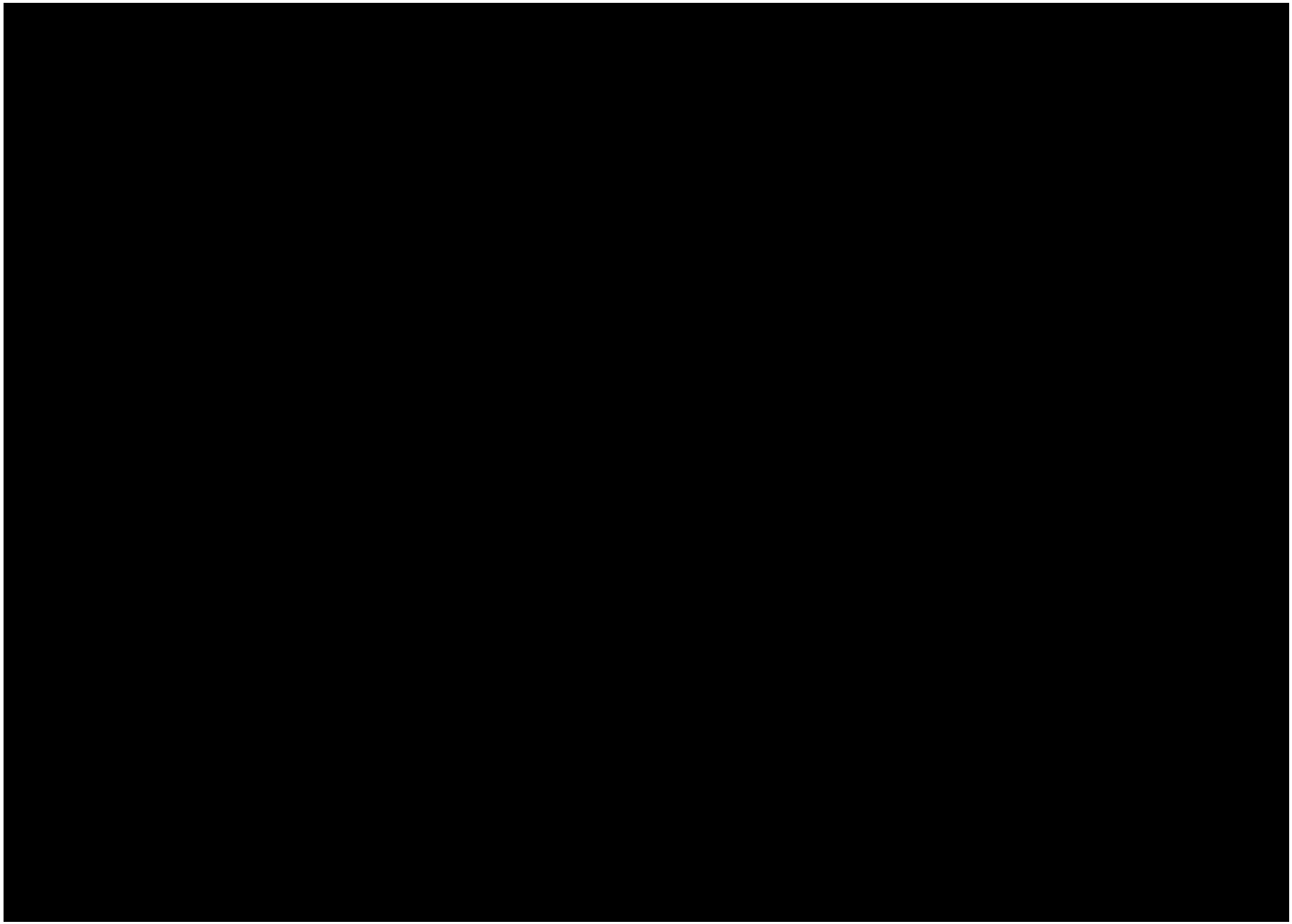


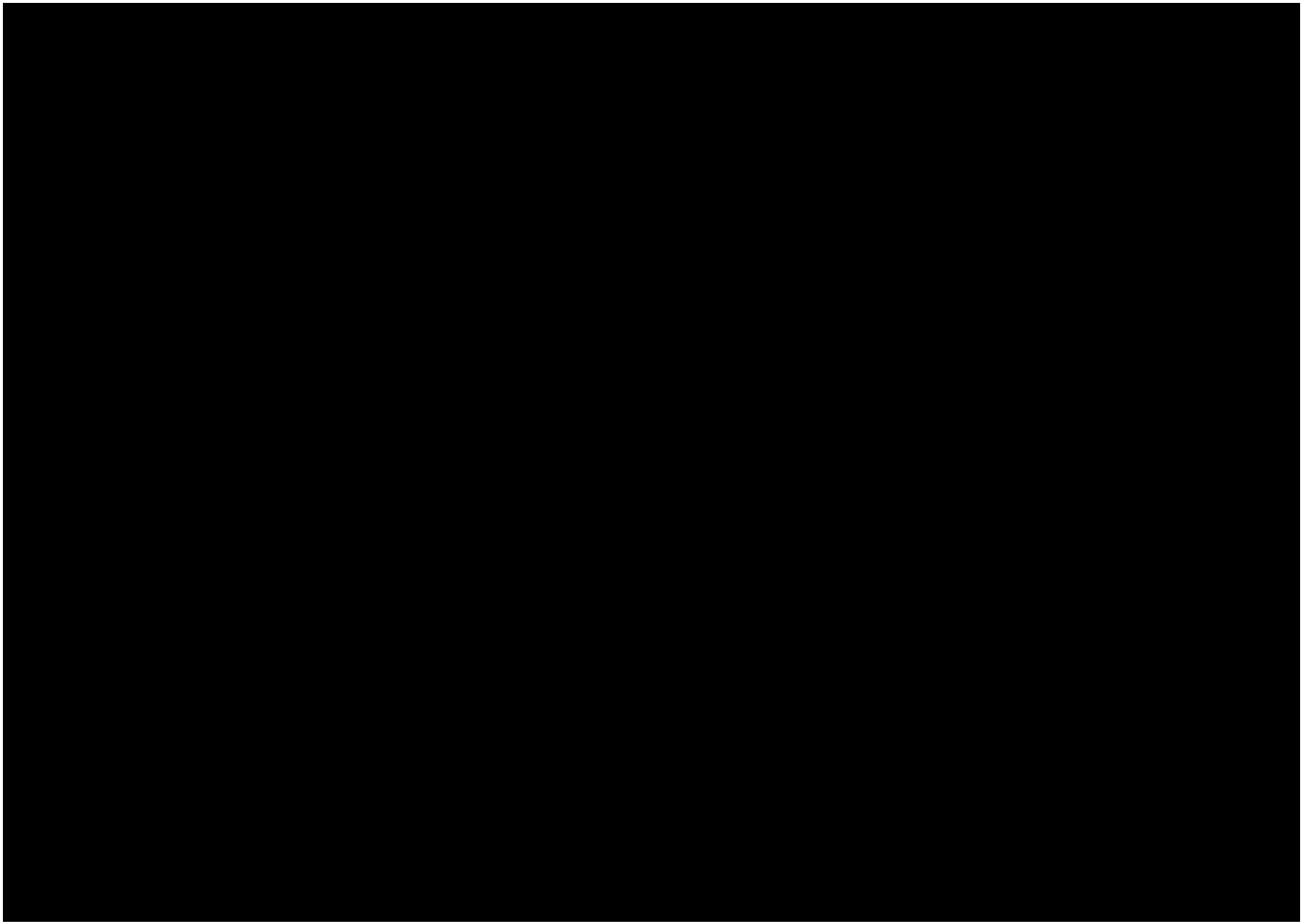


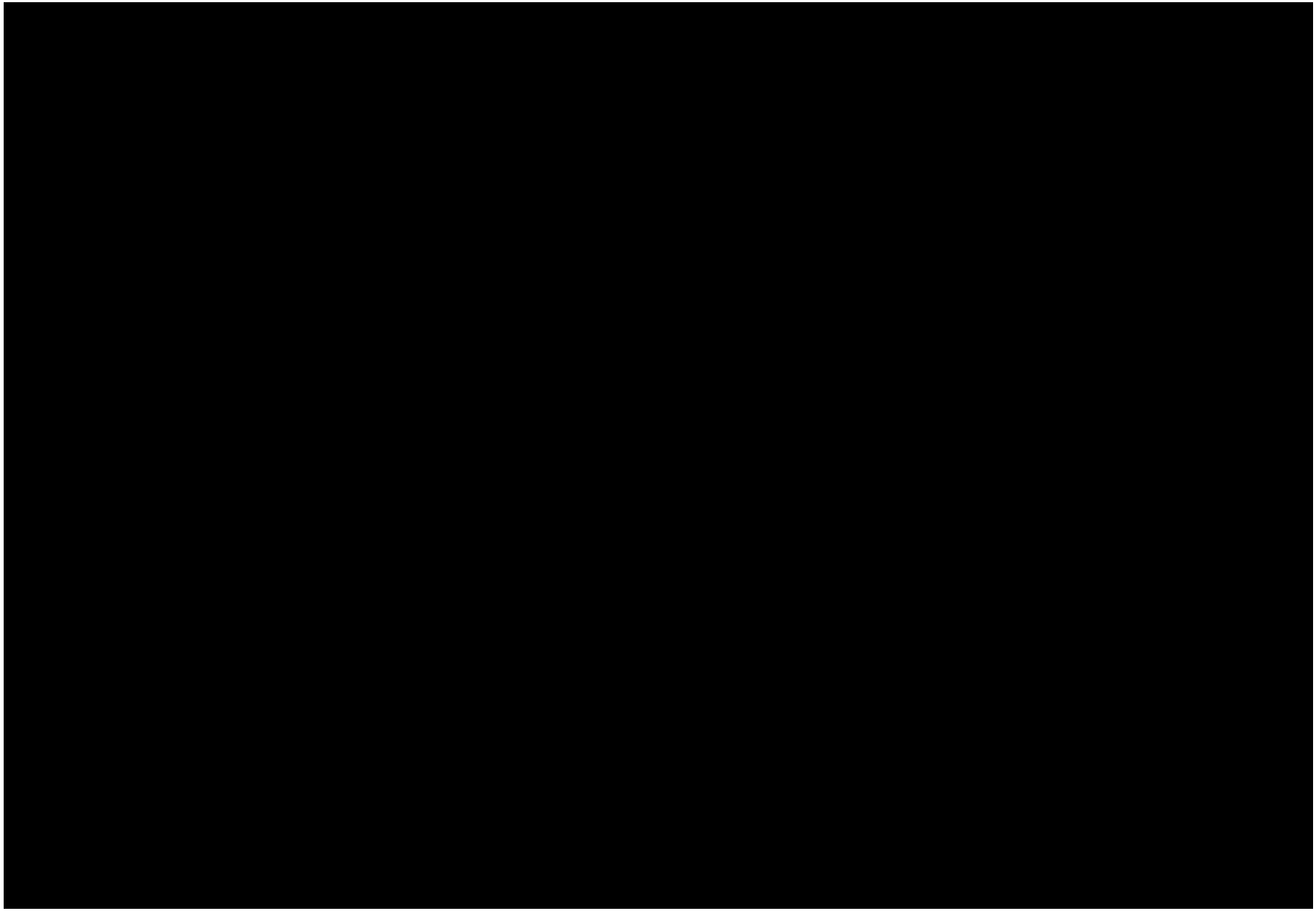


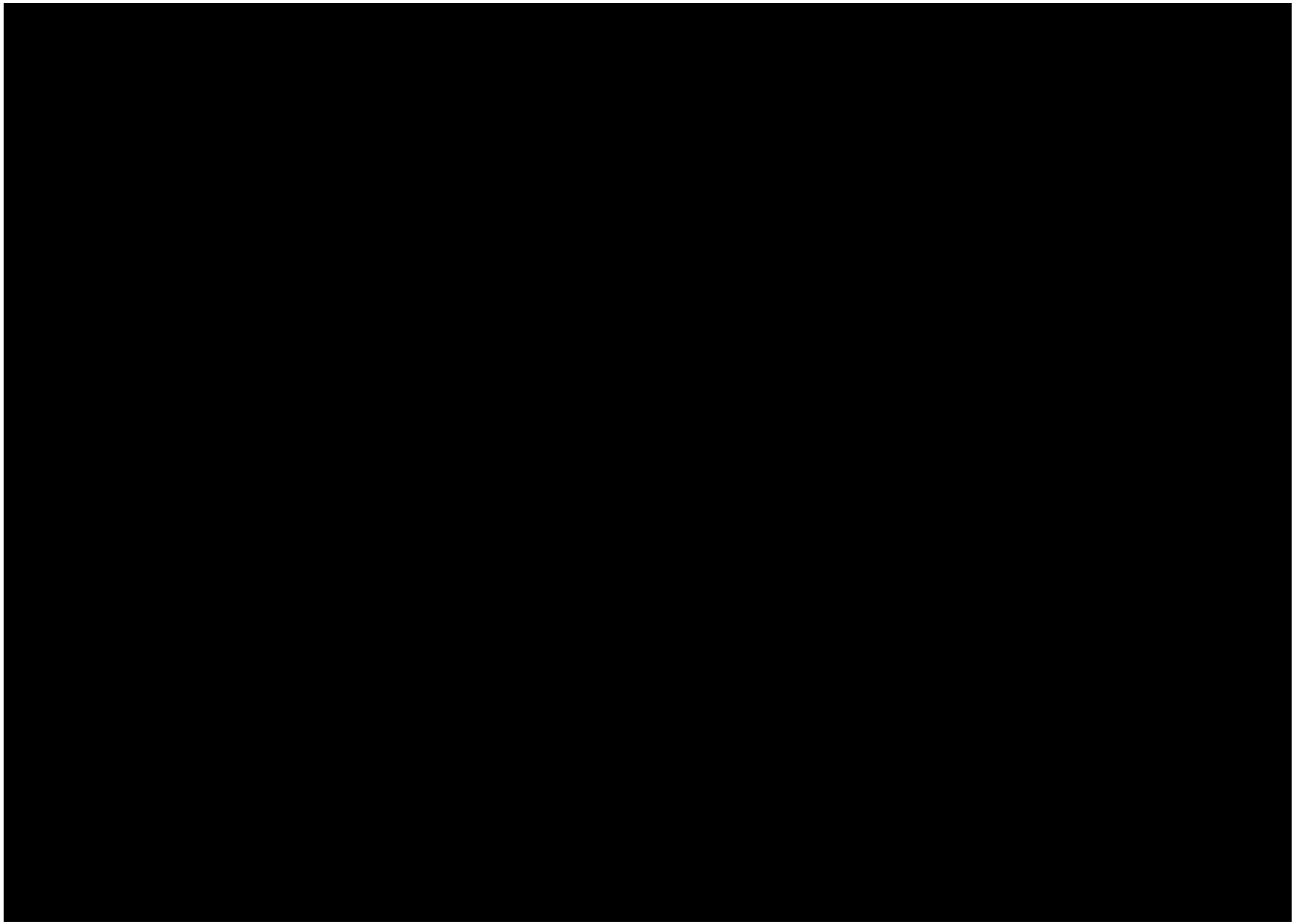


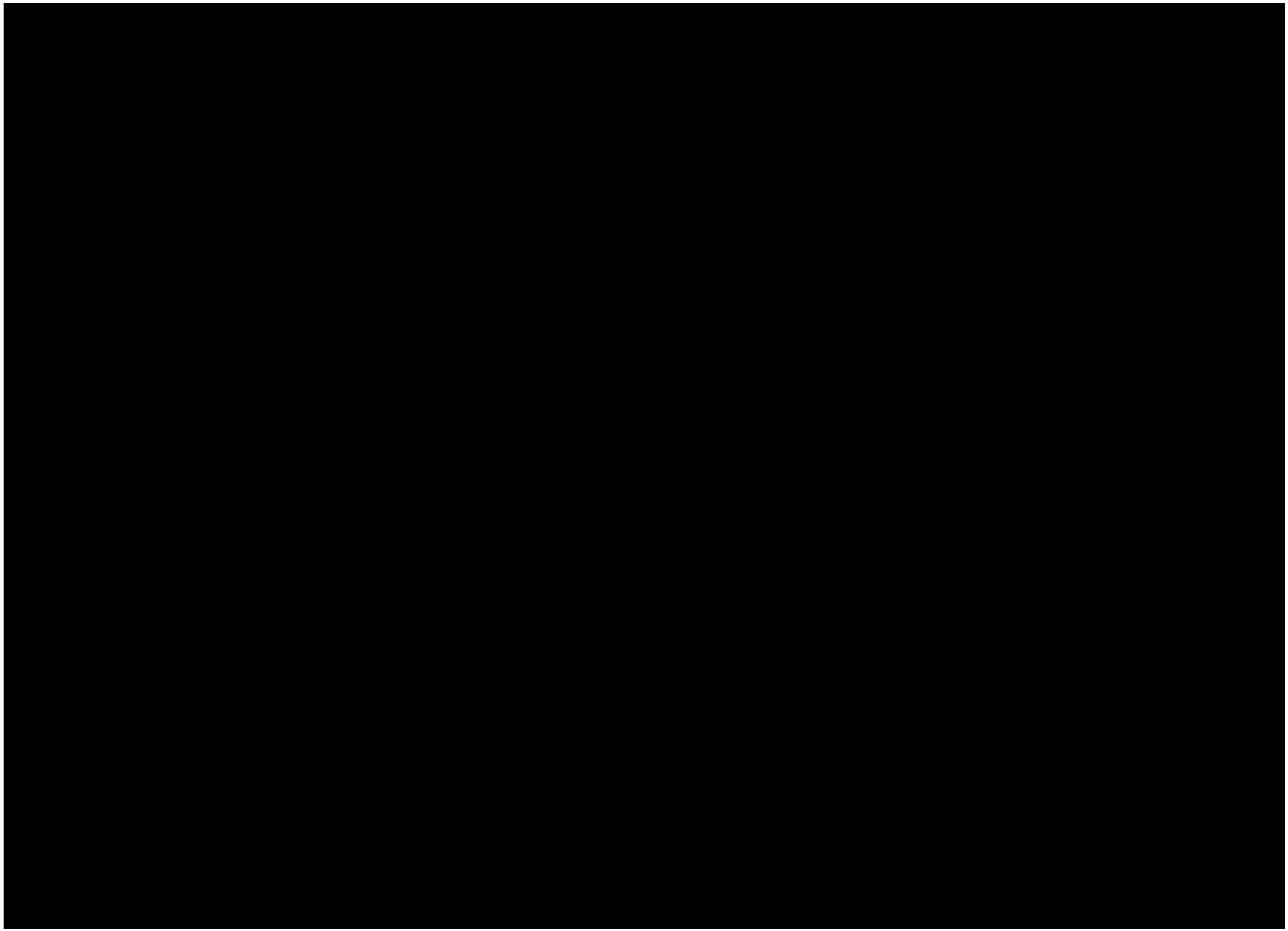


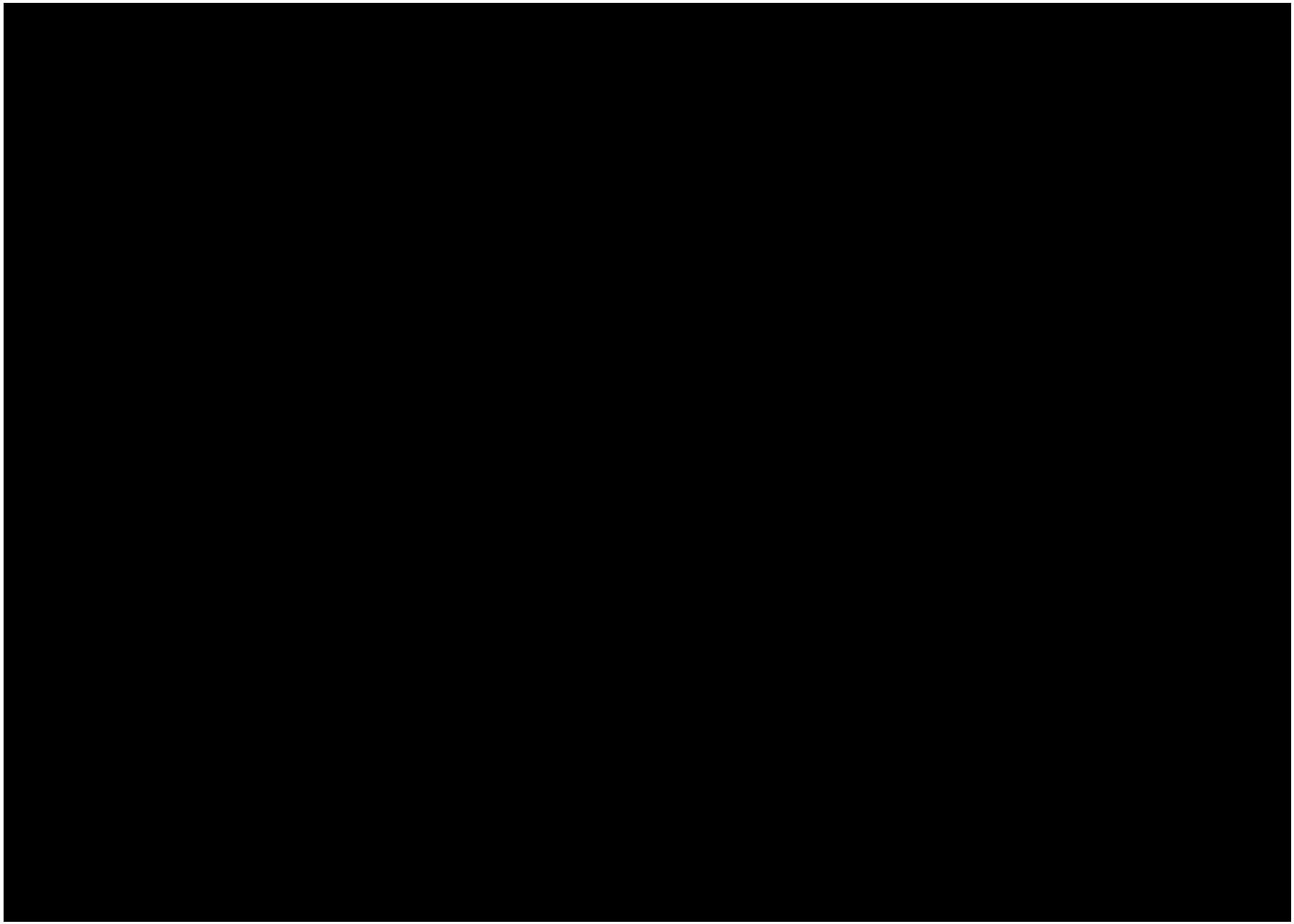


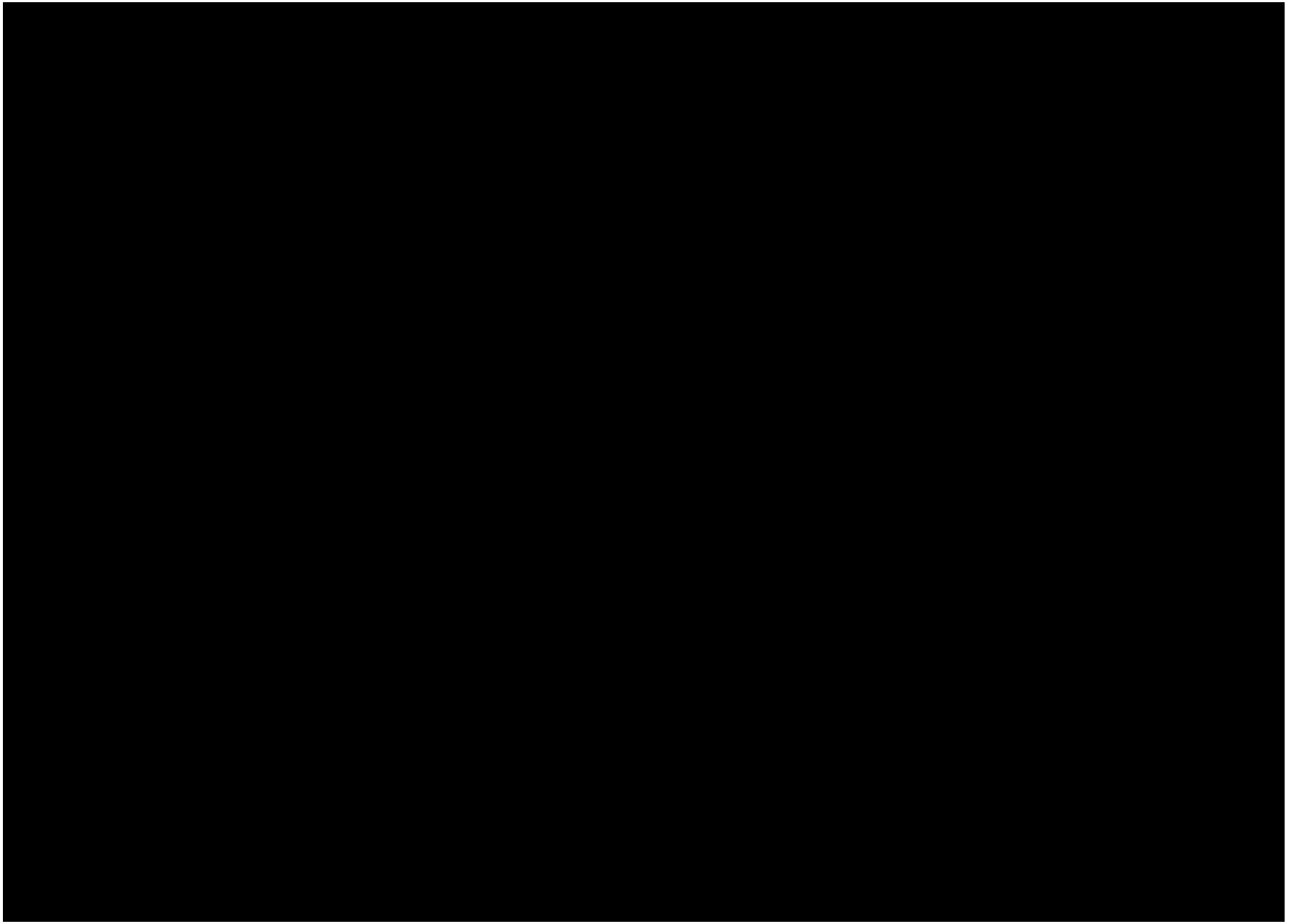


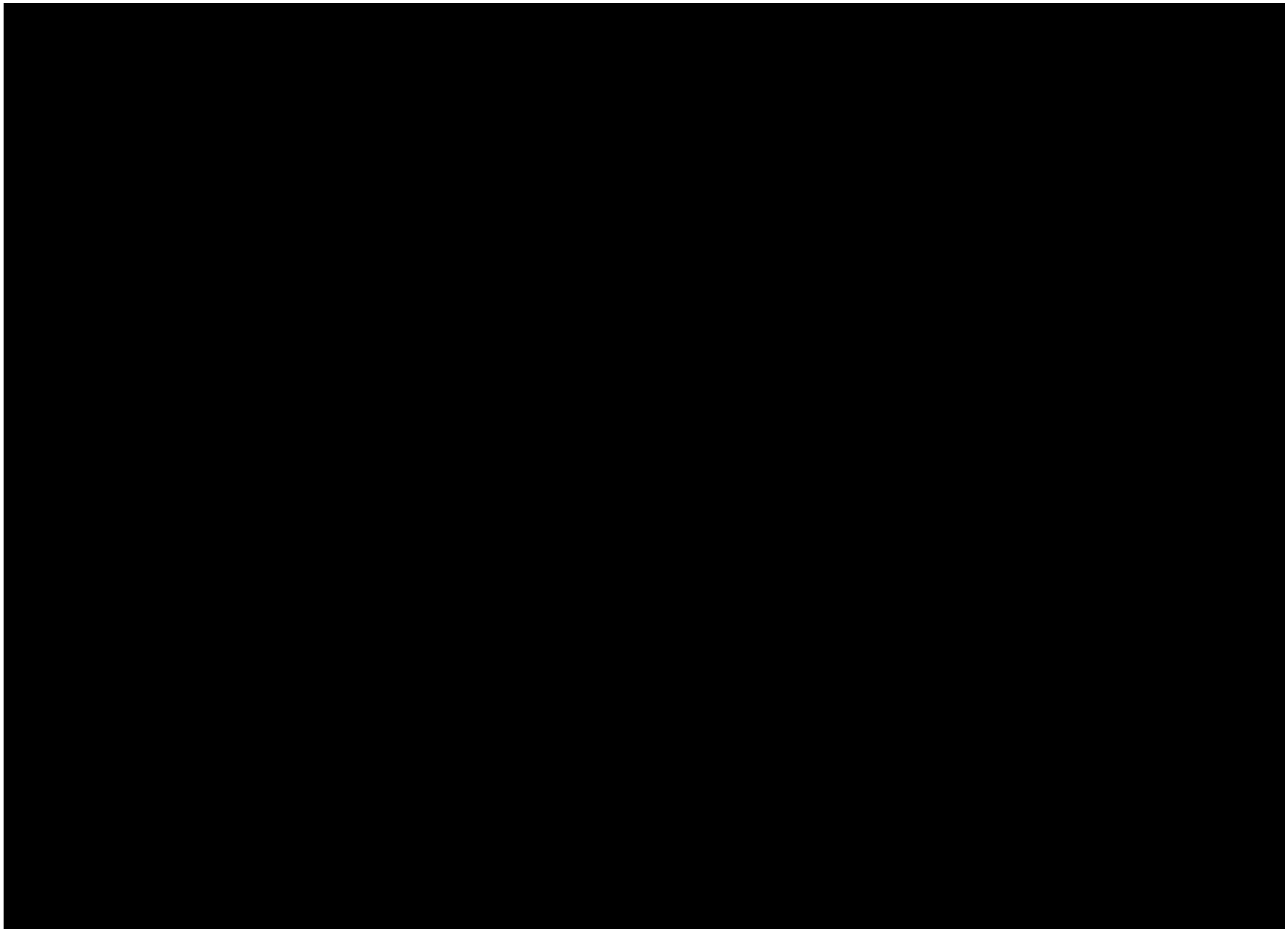


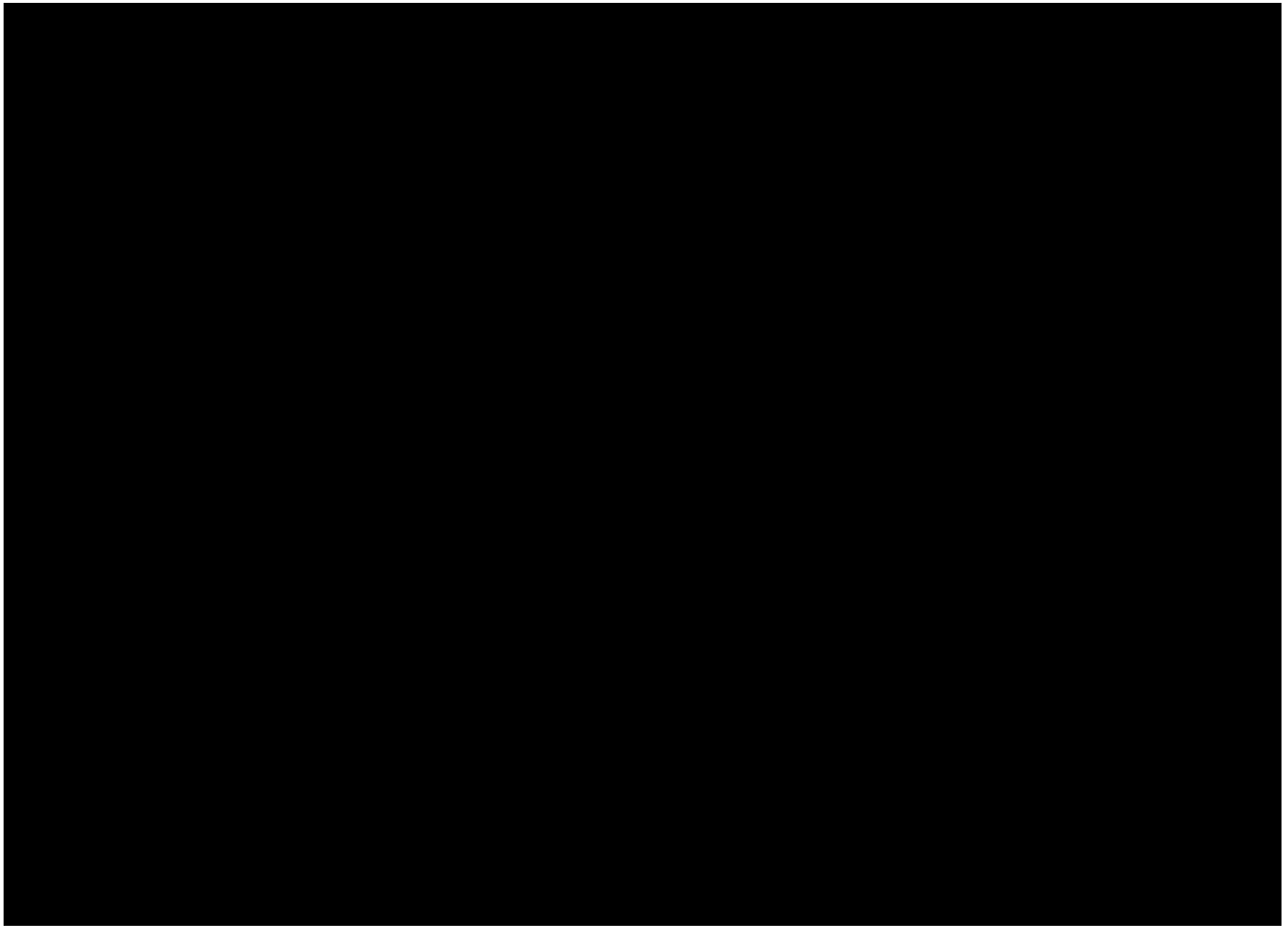


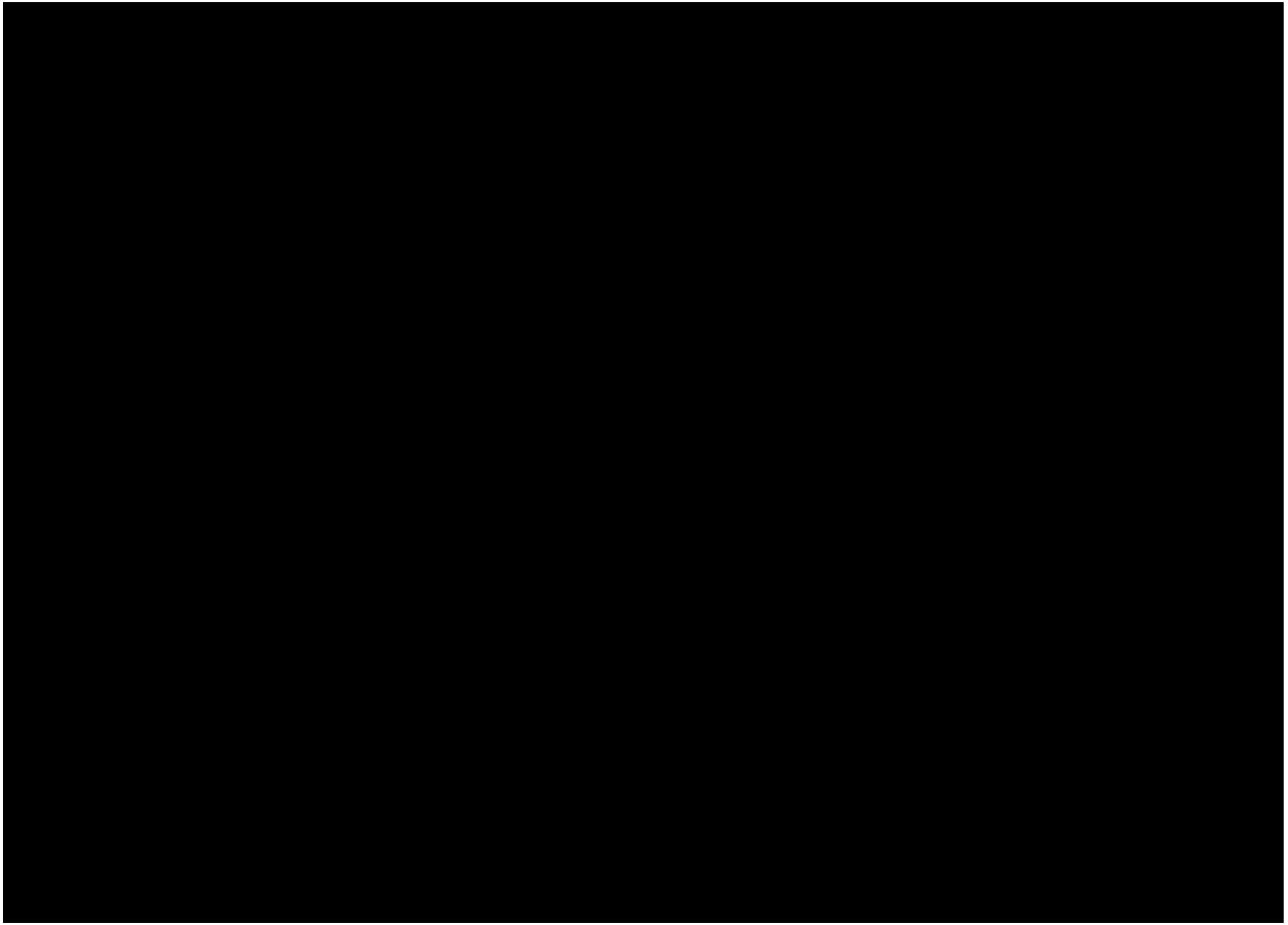


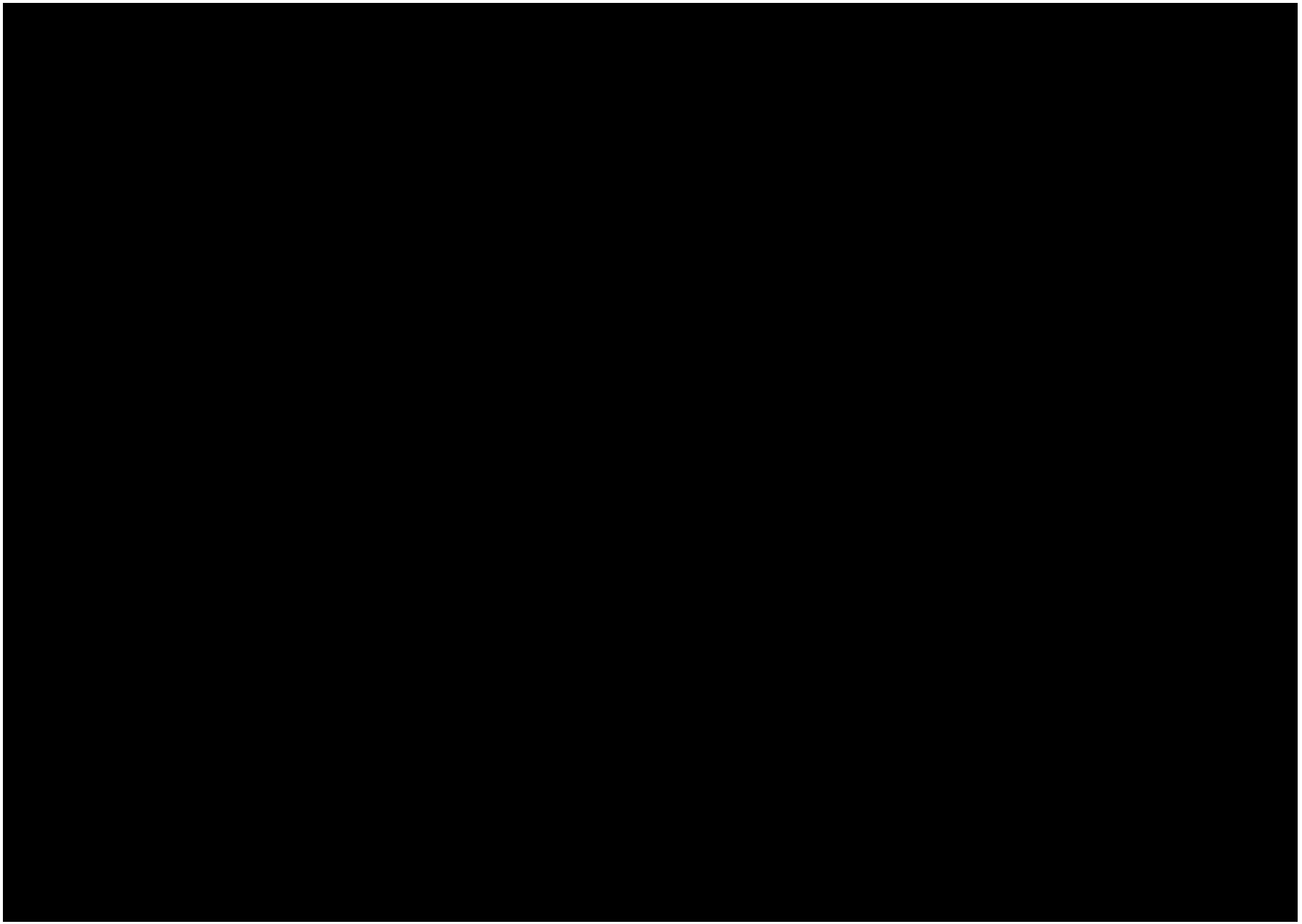


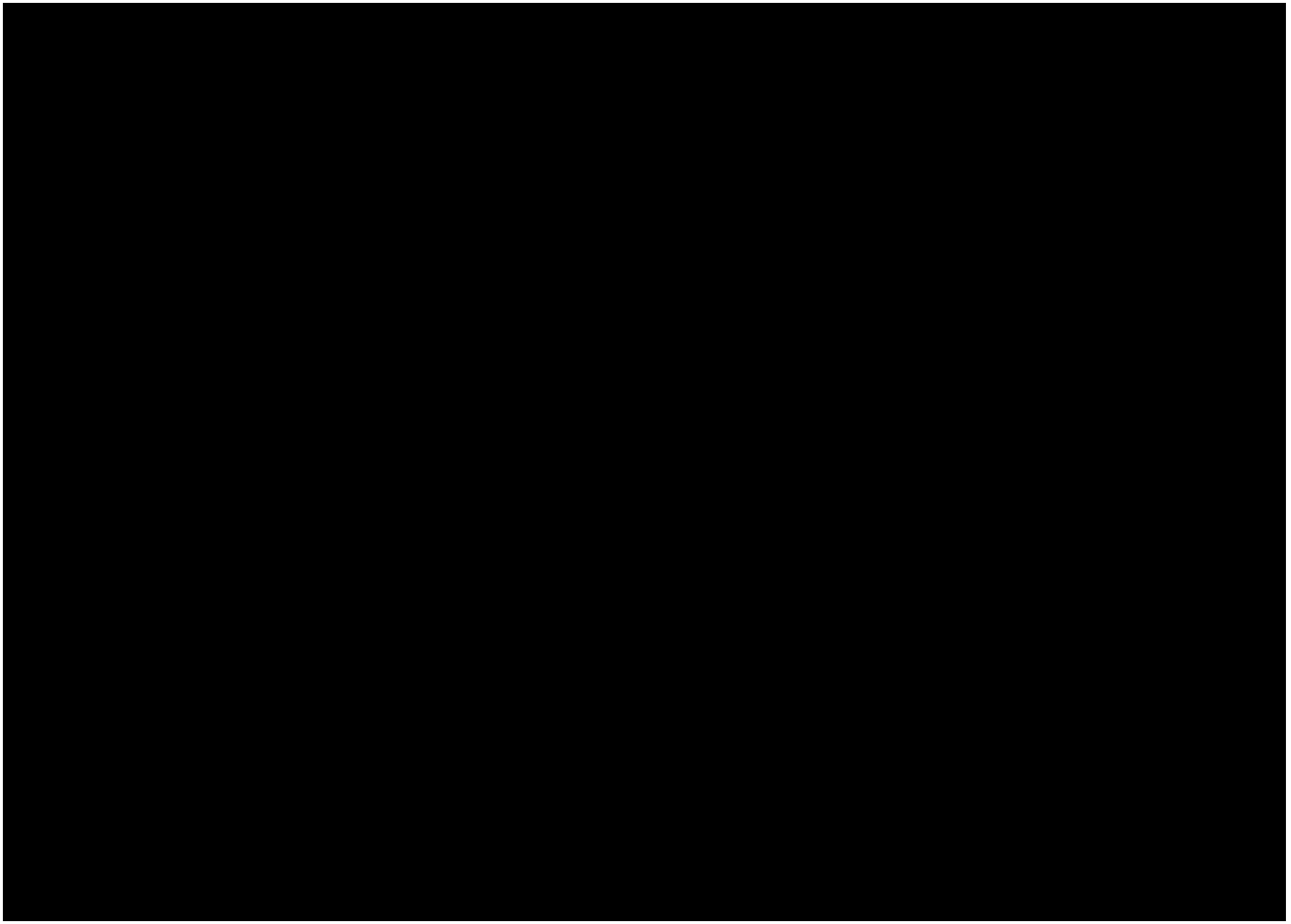


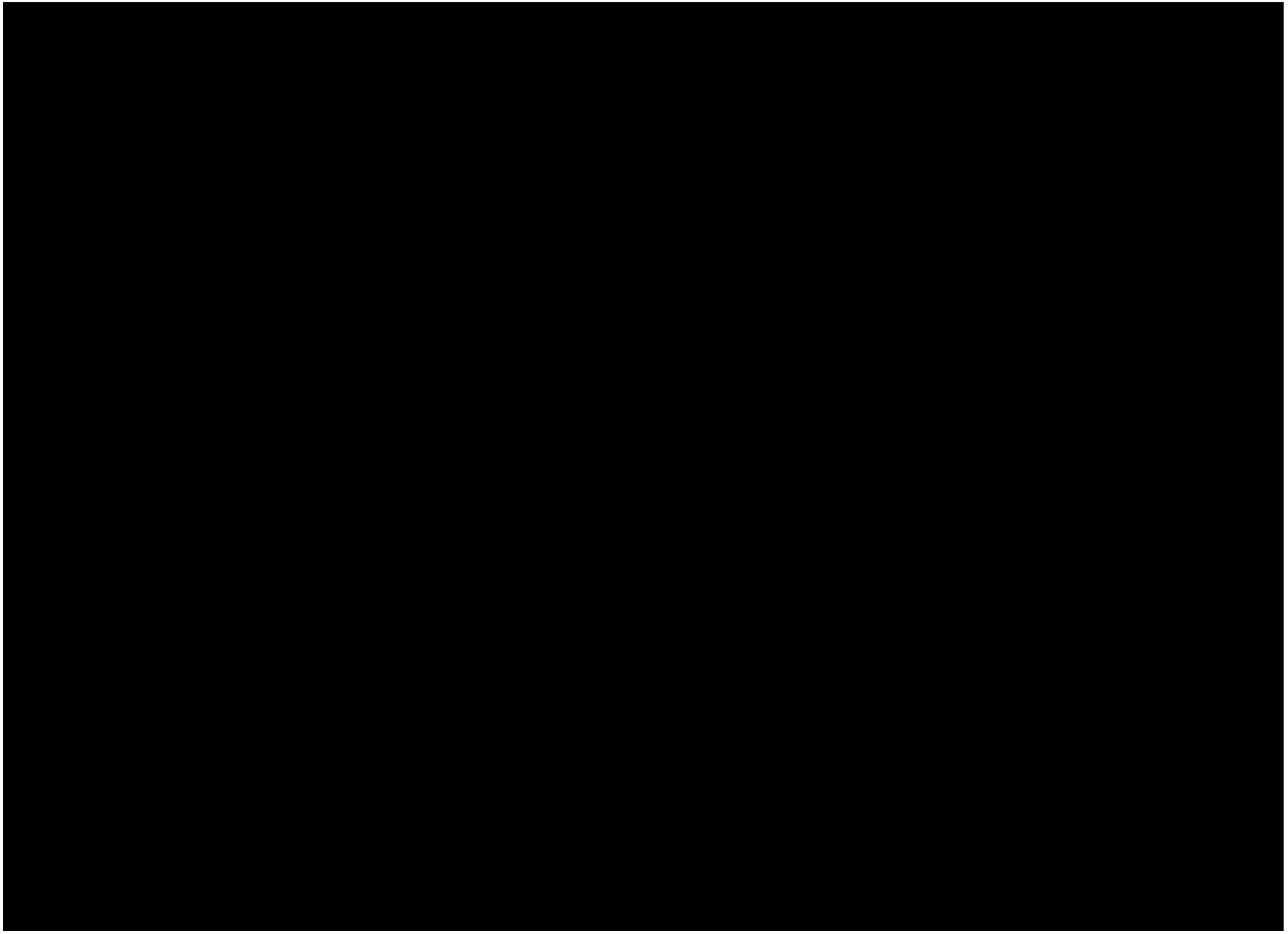


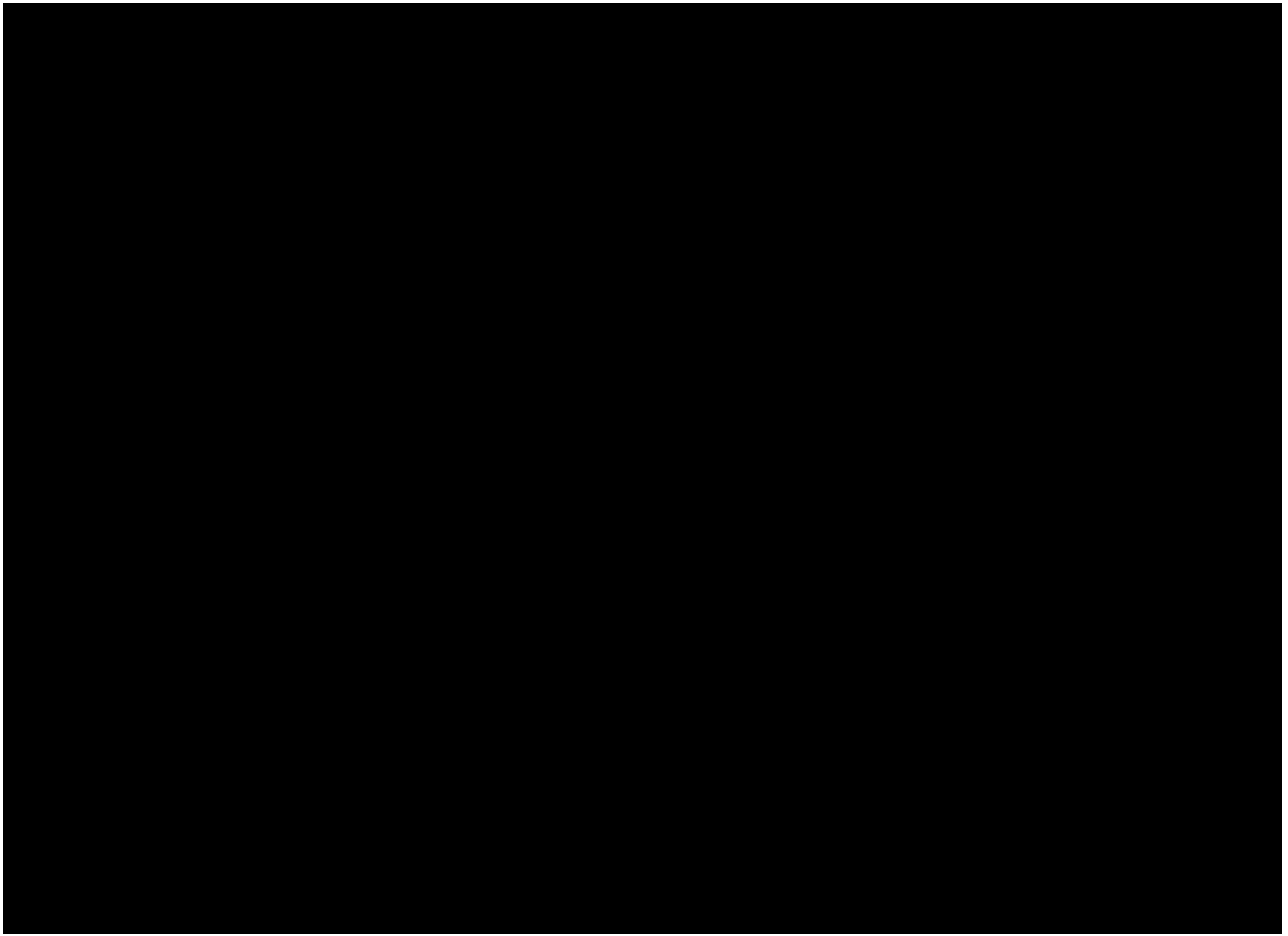


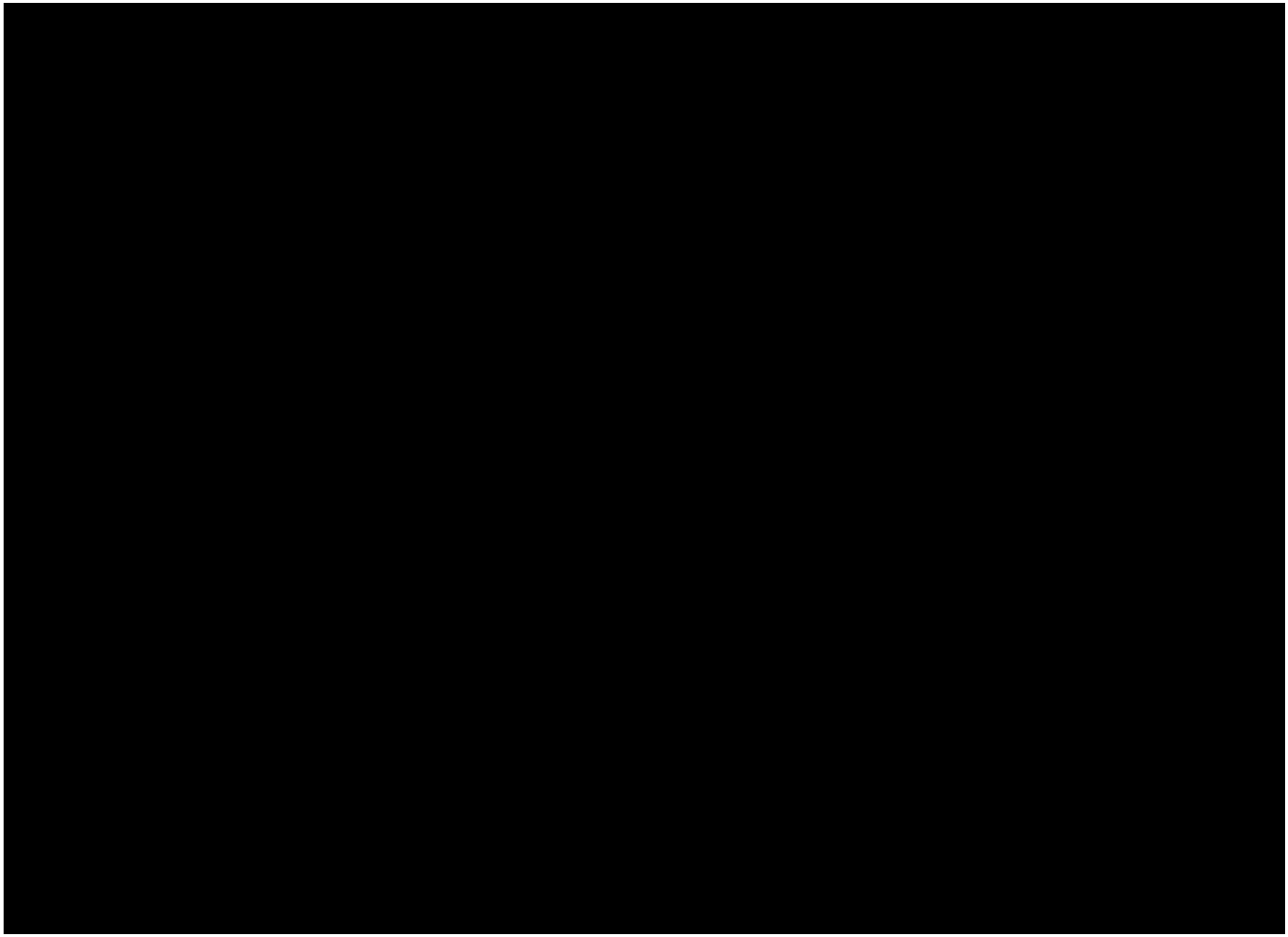


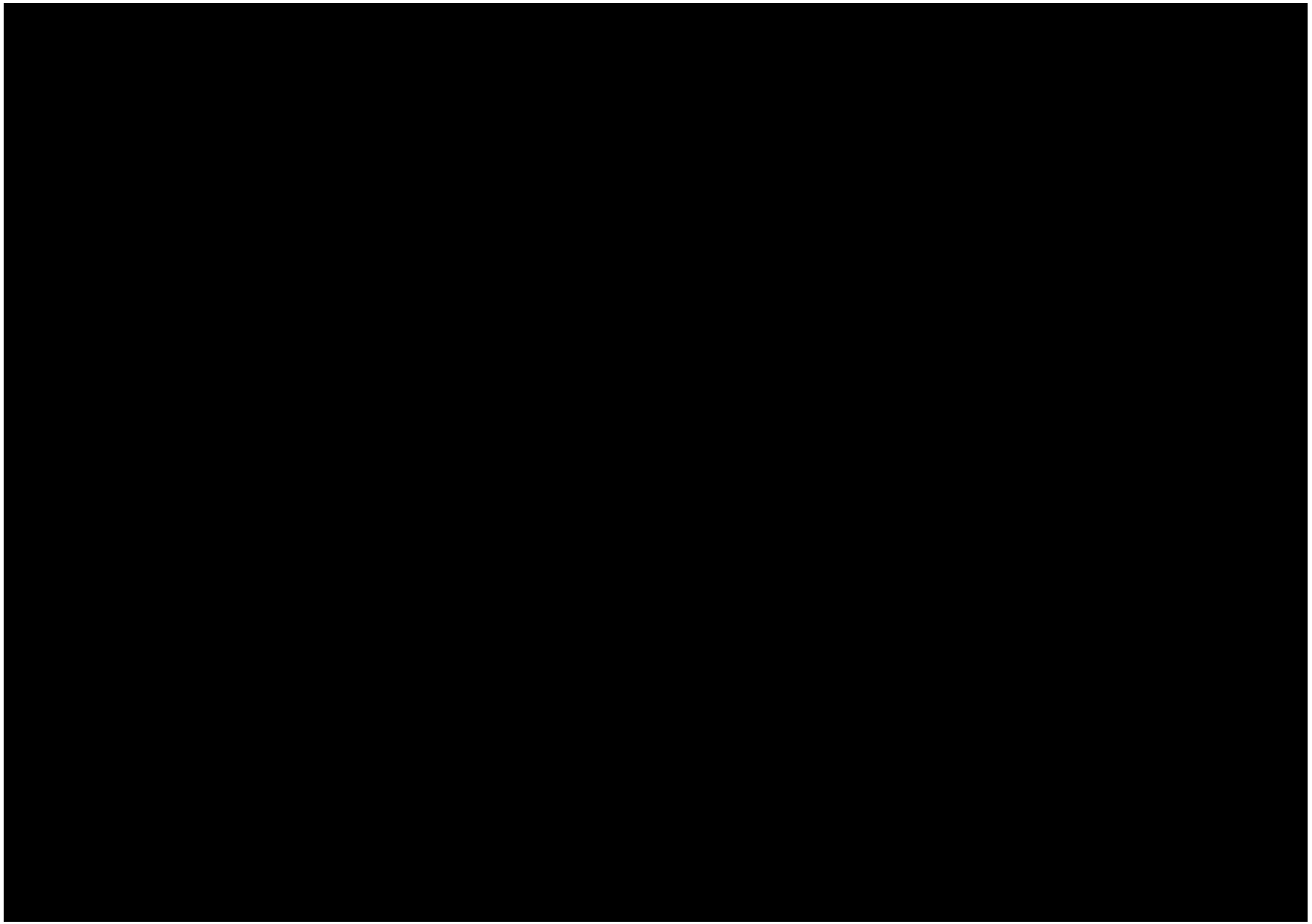


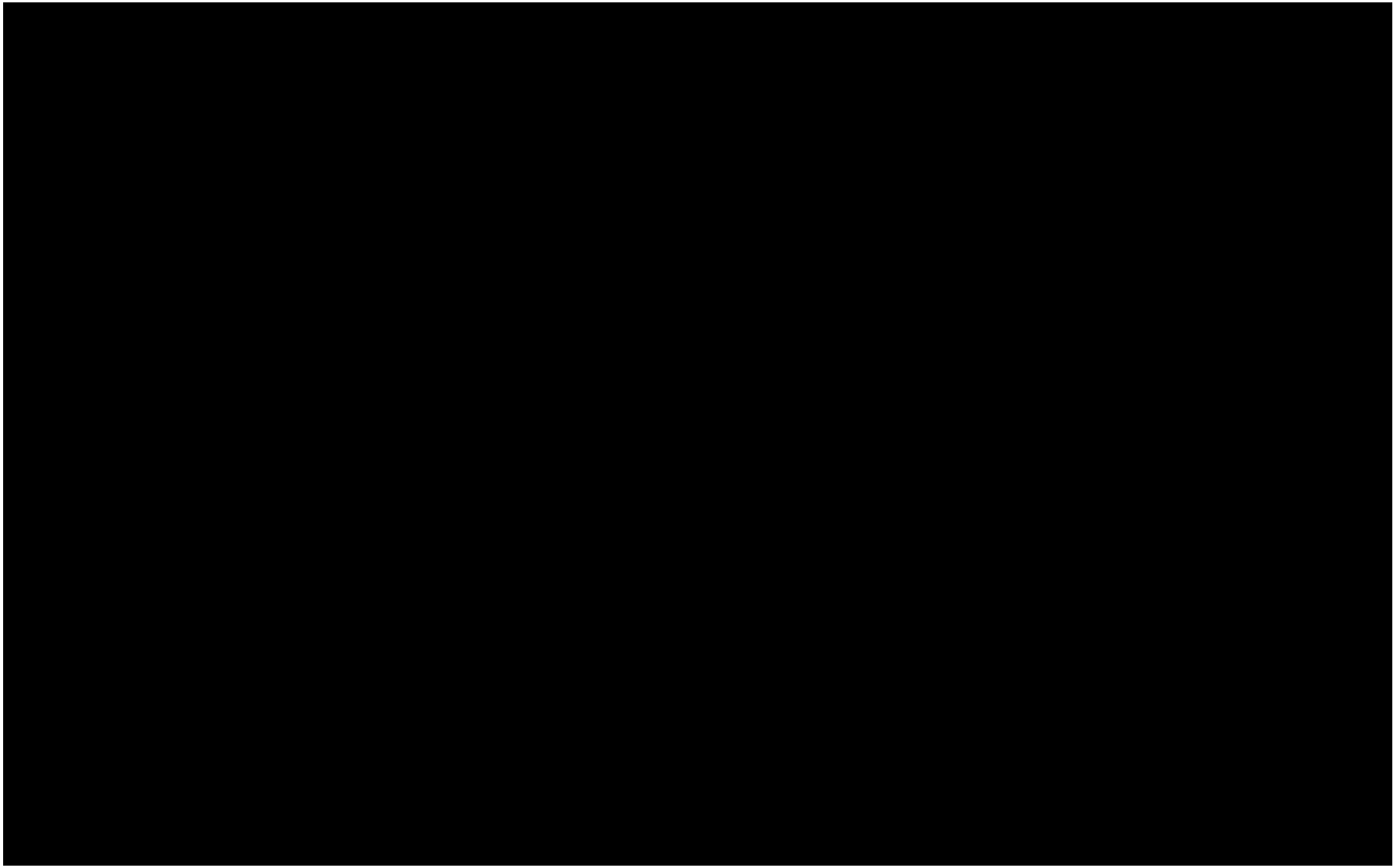


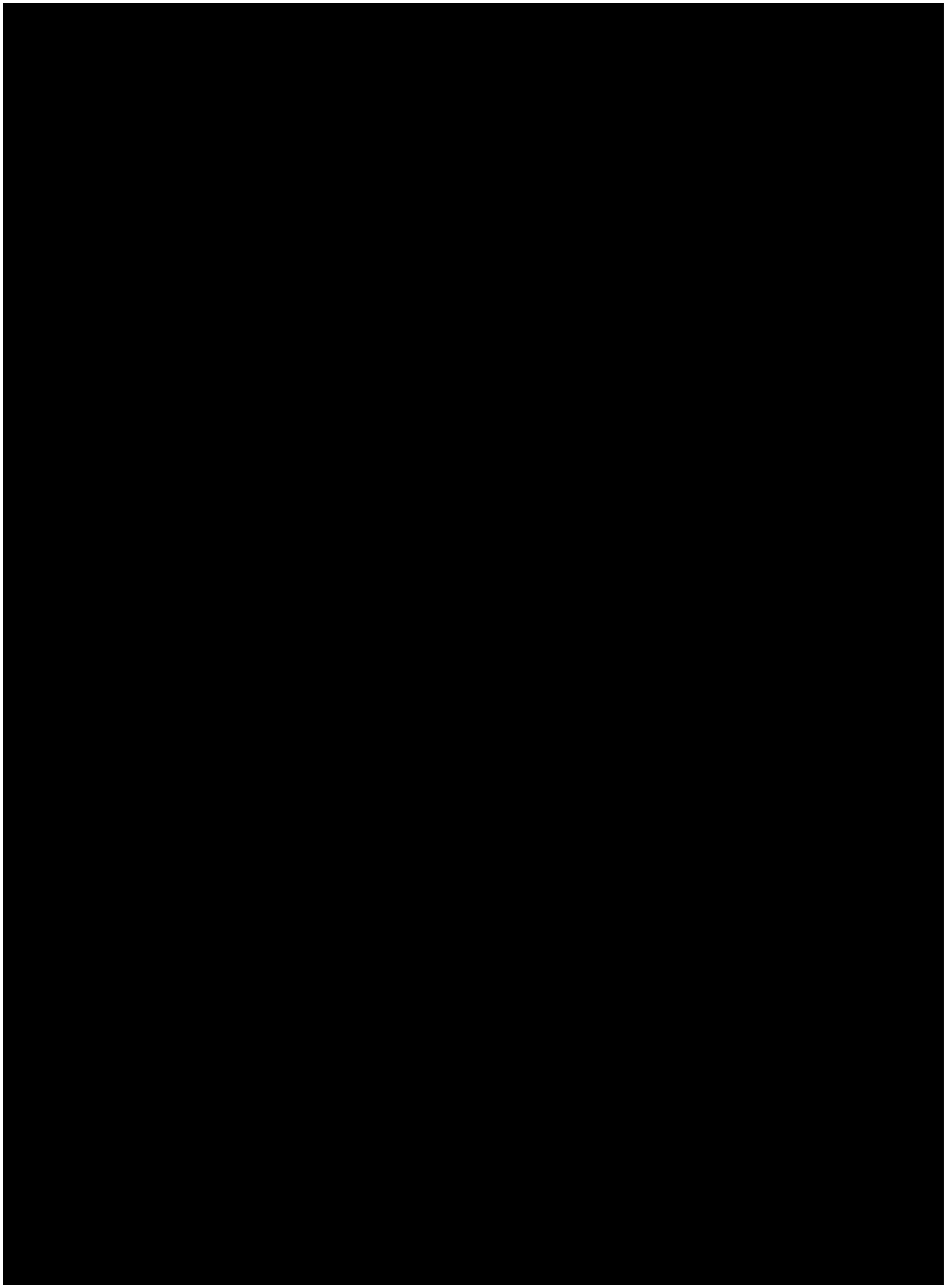


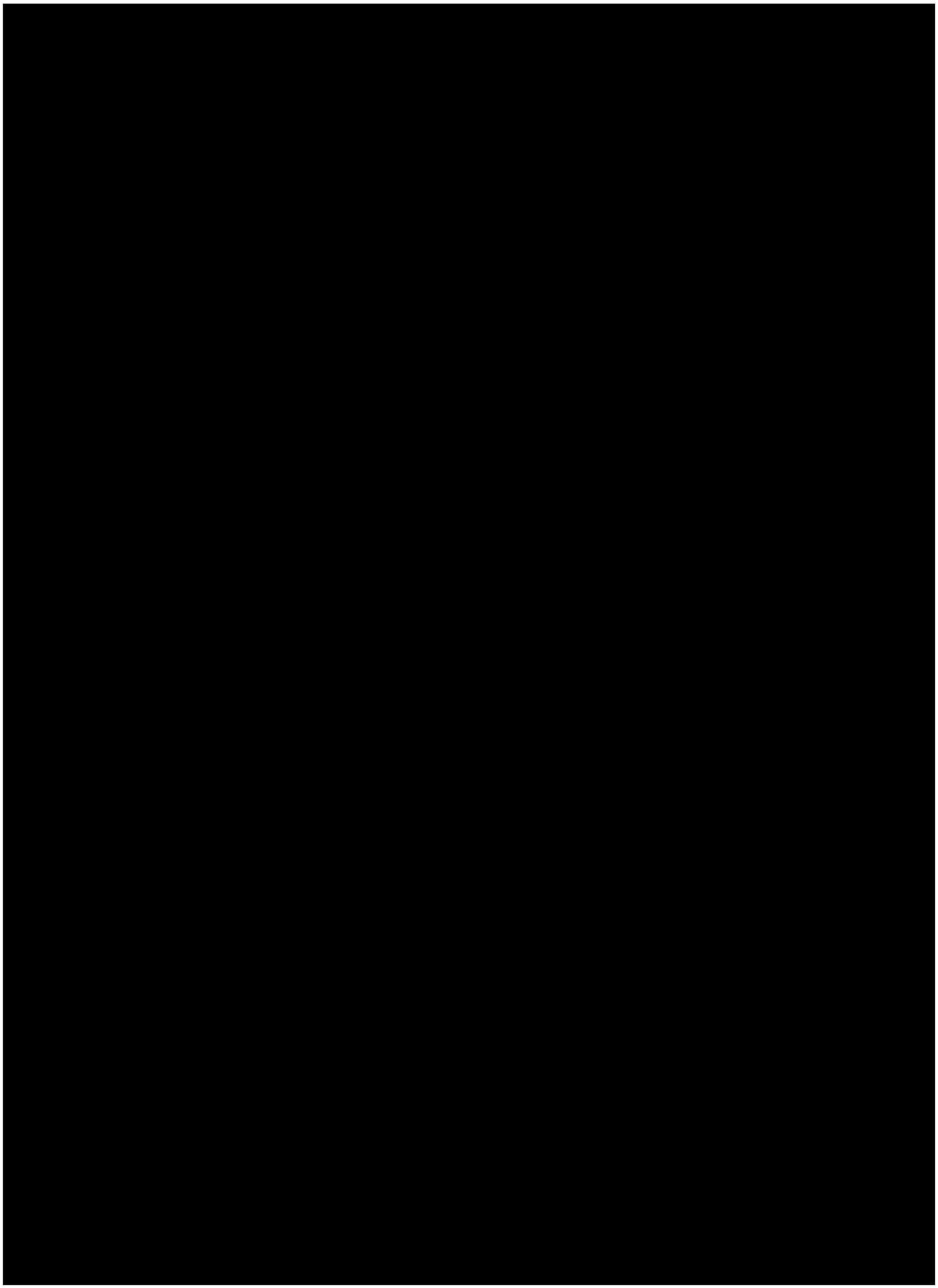


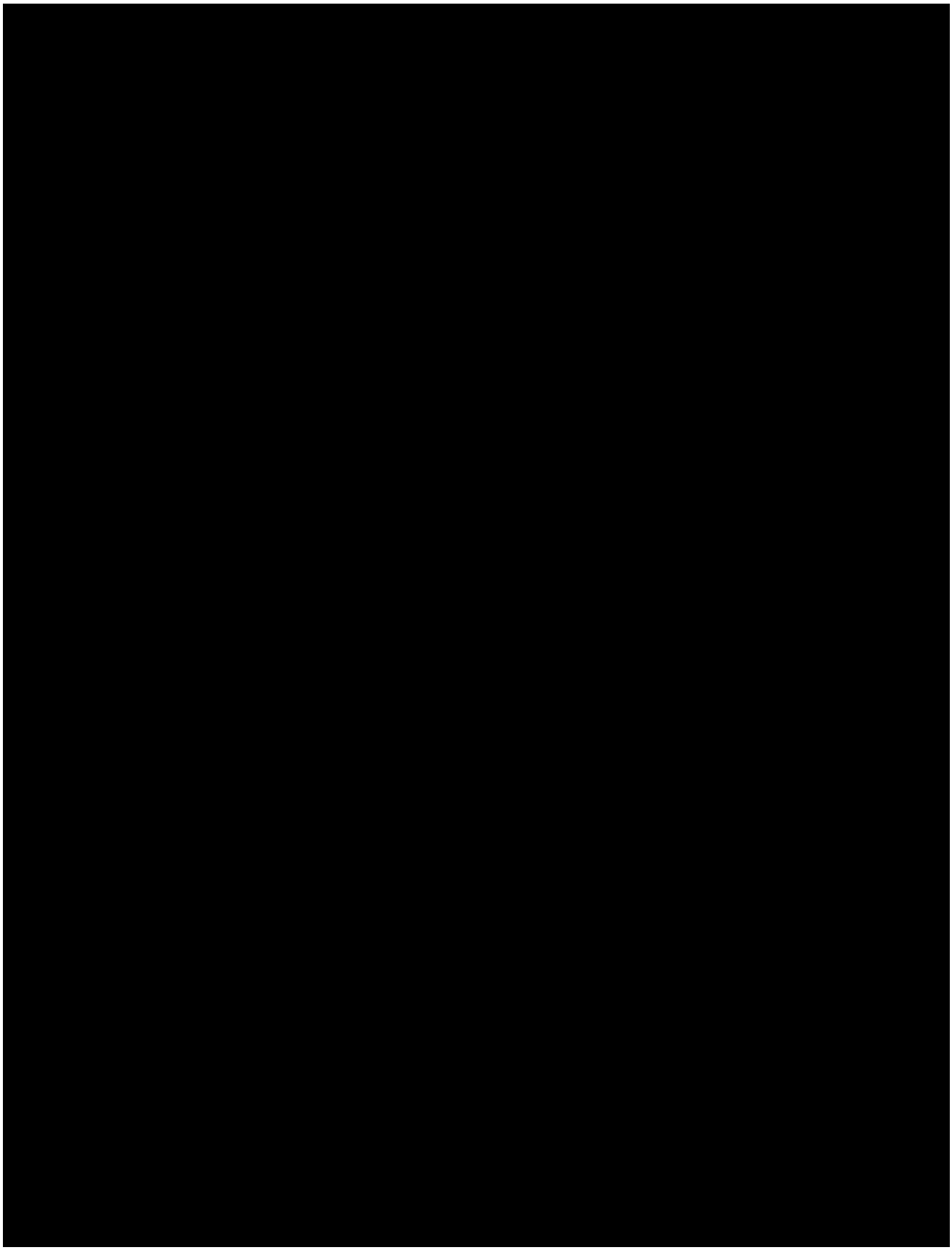


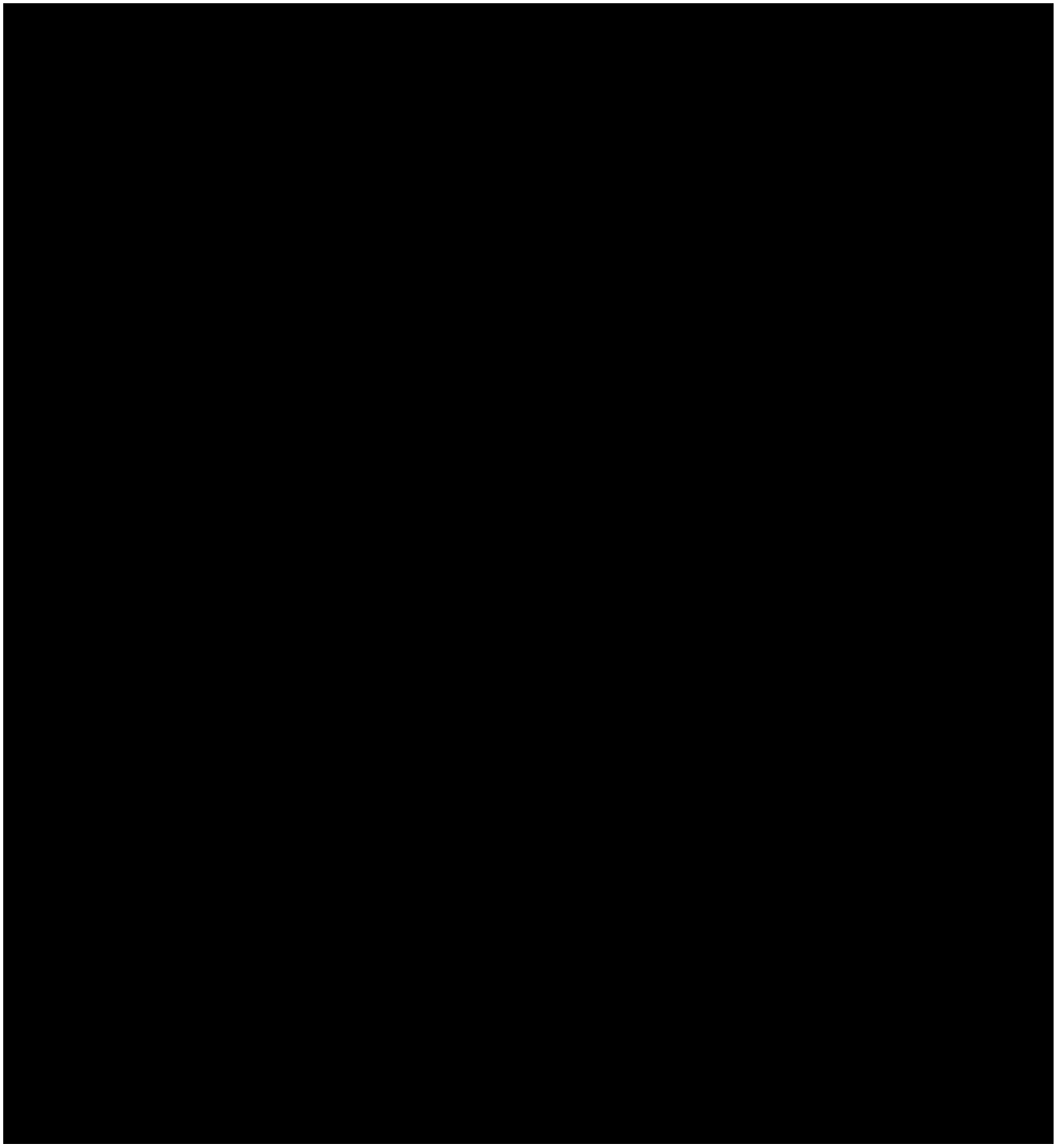












Experience and Qualifications

2. Describe an innovative approach the bidder successfully implemented in a program similar to KanCare that the bidder will use to improve timely completion of Member Health Screens in the KanCare program. Include the following in the bidder's response:

Innovative Approach Implemented in a Program Similar to KanCare

UnitedHealthcare has a rich history of innovation and operational excellence, as demonstrated by **our market-leading 91% success rate completing the Health Screening Tool (HST)** for Members we reach and are newly enrolled in KanCare, surpassing the required rate of 80%. Drawing from our extensive experience in over 25 Medicaid states, we have implemented successful strategies in Kansas that have **increased the annual number of completed HSTs by over 280% since 2021**. To achieve market-leading performance, we used various Member contact methods and continuous improvement strategies to overcome barriers to HST completion. For example, we implemented a $10 Member incentive, enhanced our member call center process, developed email and text campaigns and trained care coordinators and Community Health Workers (CHWs) on successful strategies for completing the HST. The increased completion rate has led to more complete data for stratification of Member needs, which directly impacts our status with NCQA as the top-rated managed care organization. To further our success in Kansas, we will implement the Pharmacy Health Screening Initiative we developed in Virginia, targeting difficult-to-reach Members during pharmacy interactions and enhancing their pharmacy visit using the Telehealth Pharmacy Hub.

a. A description of the innovative approach and targeted outcomes.

Our Successful Pharmacy Health Screening Initiative

UnitedHealthcare Community Plan of Virginia, under the leadership of Kristi Fowler, RPh, designed and launched a first-of-its-kind Pharmacy Health Screening Initiative. This initiative was selected by the National Alliance of State Pharmacy Associations to be the recipient of the 2021 Excellence in Innovation award. The goal of the initiative is to engage difficult-to-reach Members in the communities where they live and work during pharmacy visits to access their pharmacy benefits, work with them while on-site to complete their HST and complete other tasks that improve their overall health outcomes.

Enhancing Health Screening Tool Capabilities to Improve Health Outcomes

Building upon our strong track record of innovation, we are introducing a new pilot program in Kansas called **HST Data Complete** to revolutionize timely completion rates for HSTs. Powered by artificial intelligence, this innovative program automatically fills in HST questions using internal data from multiple sources such as claims, prior authorizations, care management records and Kansas' health information exchange, every other year. During our outbound welcome calls, we verify all the information auto-populated by our tool to confirm accuracy. Not only does this reduce HST completion time, but it also enhances overall accuracy. Results are integrated into our care coordination platform, CommunityCare, to inform the Member's care team. Our innovation decreases the length of time to complete the HST, thereby increasing completion rates by reducing Member burden and providing tailored care, education and resources — also increasing the likelihood a Member engages.

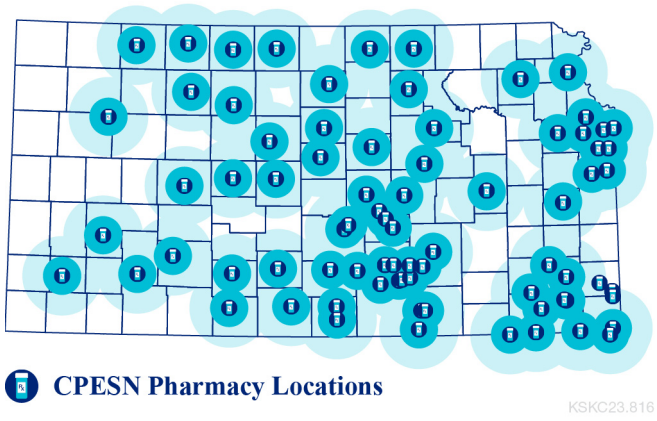
The initiative has the added benefit of partnering with local pharmacies — expanding access to care for Members, especially those in rural or frontier areas, by opening a "digital front door" for Members to address their most important health care needs using our Telehealth Pharmacy Hub. We provide Telehealth Pharmacy Hub locations with Wi-Fi-enabled devices, testing equipment and additional resources to enable them to offer services. Pharmacy technicians and, in some locations, CHWs, are on-site to assist Members with completing the HST and also initiating care through a virtual care Provider.

Pharmacy Health Screening Initiative Targeted Outcomes

Our collaboration with Community Pharmacy Enhanced Services Network (CPESN) has been instrumental in connecting with Members who were previously difficult to reach. Through this partnership, **in Virginia, we successfully engaged and completed health screenings for 20% of our difficult-to-reach Members who visit a CPESN location** — a successful initiative we are bringing to Kansas. On-site to assist Members with completing the HST, initiating care with our virtual care Doctor Chat and addressing a wide array of acute and primary care health concerns, pharmacy technicians (and, in some locations, CHWs) provide on-site evaluation and testing to support diagnostics for conditions such as flu, strep, COVID-19, UTI and testing for conditions such as diabetes (blood glucose and HbA1c), lipid profile testing, HIV and hepatitis C.

With the introduction of Telehealth Pharmacy Hubs, our aim is to deliver acute and primary care services, enhancing health outcomes and bridging the health care divide in underserved communities. We are dedicated to expanding access to comprehensive health care services and making sure individuals in areas with limited access receive the care they rightfully deserve. The figure to the right highlights the Kansas pharmacies we have already partnered with as Telehealth Pharmacy Hubs.

Figure 2-1. Kansas Pharmacy Locations engaged to be Telehealth Pharmacy Hubs



By conducting on-site HST assessments, pharmacists gain real-time insights that enable them to make recommendations to Members, ultimately improving their health. In some cases, pharmacists can provide care, such as administering vaccines, or connecting Members to virtual care through Doctor Chat. Results in Virginia have demonstrated an increase in primary care visits and enhanced engagement in care management for Members who can benefit from coordinated care. Combining our resources and expertise and using the reach of community pharmacies, we are confident the Pharmacy Health Screening Initiative will continue to increase HST completion rates and lead to improved health outcomes and a reduction in health care disparities across the state.

b. How the bidder measured and monitored improvement.

Measuring and Monitoring the Pharmacy Health Screening Initiative

Our Health Screening Tool Dashboard (HST Dashboard) is a powerful tool that enables us to effectively monitor and analyze the results of health screenings for our Members. With the HST

Dashboard, we can easily filter and track our membership based on eligibility category, age, location, outreach method and other details in real time to assess the success of individual health screening campaigns and pinpoint areas for enhancement in completion rates. In Virginia, we successfully monitored the number of health screenings completed and measured the improvements in timely completion rates when conducted in person at one of our CPESN pharmacies. Meanwhile, our data from Kansas revealed that approximately one-third of completed screenings were the direct result of our email outreach, which provided Members with a convenient digital assessment option. This valuable insight prompted us to establish a "digital front door" initiative in collaboration with local pharmacies across the state. Now, our Members can complete the HST in person or digitally at a CPESN pharmacy, offering them flexibility and convenience. And, using the HST Dashboard, we continually measure and monitor the progress of enhanced completion rates for Members who complete the HST at a CPESN pharmacy.

Our initiative is further bolstered by the CPESN Hotspotting tool, which empowers us to measure and monitor the impact of each pharmacy on health outcomes, both at a summary level and on an individual Member basis. As shown in the figure, the Hotspotting Data Tool provides a glimpse into the reportable data we obtain. In Virginia, CPESN pharmacies that complete the HST with a Member who is recommended for care management referral experience a **34% increase in enrollment in care management** due to the education they receive about its benefits and importance. Further, Members who undergo on-site screenings are **47% more likely to schedule timely primary care visits**, as recommended by the pharmacist. The HST data collected at CPESN locations also enables us to identify key health concerns within communities. For example, in Petersburg, Virginia, we discovered a high prevalence of diabetes. In response, we joined forces with a CPESN partner, Walnut Hill Pharmacy, to launch a Food Pharmacy pilot program. This innovative initiative offers Members with diabetes a food box containing 40 medically tailored meals, aiming to enhance their overall health and well-being.

Figure 2-2. Our Hotspotting Data Tool

The Pharmacy Health Screening Initiative is further supported by CPESN, which provides a well-established platform for tracking successful engagement with our Members. Through CPESN's Electronic Quality Improvement Platform for Payers and Pharmacies (EQUIPP), we exchange near real-time data with CPESN pharmacies. This exchange includes updated contact information for difficult-to-reach Members, completed assessments, health screening and test results, and other important data that helps us improve the program. For example, we can identify which pharmacies are completing the highest volumes of HSTs and the most effective

time of day and day of the week for screenings. This information helps when a CHW is on-site to provide further education and support for any SDOH needs identified in the assessments, contributing to closing gaps in health disparities.

By leveraging the HST Dashboard, CPESN Hotspotting tool and EQUIPP, we have a comprehensive and data-driven approach to continuously improve our Pharmacy Health Screening program. As a result, we are able to make better informed decisions and adapt our strategies based on what works best for our Members. With real-time data at our fingertips, we can identify successful engagement methods, optimize program delivery and improve the health outcomes of our Members.

c. Lessons learned.

Lessons Learned

Through our pharmacy-based initiatives that enhance HST completion rates and foster engagement with primary care, we have discovered that Members who have in-person interactions at pharmacies demonstrate a higher rate of HST completion and place greater trust in their local pharmacists, leading them to actively participate in their health care. Building upon this knowledge, we will collaborate with key CPESN pharmacies across Kansas to develop targeted programs that address primary health disparities prevalent in their respective communities. For instance, we have identified that more than 10% of adults in Finney County have been diagnosed with diabetes. Drawing from the successful learnings and best practices of our Food Pharmacy pilot in Virginia, we will establish a similar food-as-medicine program, partnering with a local pharmacy to enroll Members identified as high risk through the HST who require diabetes management support. Moreover, our CPESN partners already possess the necessary capabilities to conduct HbAlc screenings for our Members, enabling us to track and monitor the pilot's impact on community health outcomes. By leveraging the established and trusted relationships between local pharmacists and our Members, we can make significant strides in reducing health disparities across the Kansas communities we proudly serve.

d. The measurable improvement achieved; and why the bidder anticipates the approach will be successful for improving timely completion of Member Health Screens in the KanCare program.

Measurable Improvement Achieved and Anticipated Success in Kansas

Pharmacists in Kansas are well positioned to identify and target difficult-to-reach Members with incomplete health screenings, similar to our experience in Virginia. Our Virginia community pharmacy partners have shown consistent success in improving timely completion rates for HST by 20% for Members who were previously unreachable by our internal team, and these results have been replicated in 13 other states. This initiative has also consistently demonstrated a significant improvement in care management engagement and improved primary care engagement. As we implement the Pharmacy Health Screening Initiative in Kansas, we will closely monitor engagement rates and establish benchmarks to measure health outcomes for specific diagnostics such as HbA1c for diabetes or improvements in the number of timely PCP visits.

In addition, we will track successful virtual visits with Providers through our telehealth service, Doctor Chat, which connects Members to Providers via video chat through an app or web portal. We will also focus on the administration of vital vaccines like COVID-19 and influenza.

Telehealth Pharmacy Hub Member Experience

Situation: A Member was recently incarcerated and, post-release, was having a challenging time getting an appointment with a local Provider.

Intervention: We arranged for telehealth service at the pharmacy hub and were able to get him on appropriate post-stroke care, start a tobacco cessation program and get refills on his medications that were due to expire.

Outcome: After using the Telehealth Pharmacy Hub, the Member said he had never seen a pharmacy like us before and expressed immense gratitude to the pharmacy technician for helping him get back on track.

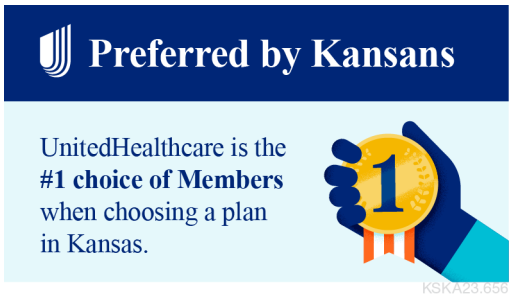
By setting objective, measurable goals for these health care tasks and leveraging the expertise of our pharmacists, the power of telehealth hub technology and our new pharmacy partnership programs, we are advancing toward increased accessibility, efficiency and patient centricity. This transformative innovation has driven higher engagement and HST completion rates in both rural and non-rural areas of Virginia, and we anticipate a similarly positive impact in Kansas.

e. The projected impact on the KanCare program

Projected Impact on the KanCare Program

Drawing from our experience in Virginia, other states where the model is active and our local expertise in Kansas, we anticipate the following outcomes:

- Based on our analysis of current membership data in Kansas, we have identified that 13,000 Members are currently using one of the CPESN pharmacies in the state. CPESN has shown success in **reaching 20% of difficult-to-reach Members** who visit their pharmacies. Based on these findings, we anticipate that the Pharmacy Health Screening Initiative will enable us to complete an additional **2,250 HSTs per year, representing a 15% increase.**
- We project that at least 70% of Members who complete an HST at a CPESN location will have a primary care visit within 12 months of completing the assessment.
- We project that care management enrollment will increase at least 30% for Members who complete an HST at a CPESN location.



UnitedHealthcare is the most preferred managed care organization in the KanCare program because of our commitment to implementing impactful solutions that improve the health and wellness of our Members. Initiatives like the Pharmacy Health Screening, combined with our on-site health care capabilities, empower our Members to access the care they need on their terms, reducing health and access disparities. We strive each day to provide our Members with the care they want, where and when they want it, while prioritizing their overall well-being.

Experience and Qualifications

3. The State is seeking to contract with MCOs that will be collaborative, adaptable, and supportive partners with the State, Providers, Medicaid Fiscal Agent, and each other to achieve the State's vision and goals for the KanCare program. Describe the actions the bidder will take to be an effective partner. Include specific examples of the bidder's experience with such partnering in a program similar to KanCare and how that experience will be leveraged to promote partnering in KanCare.

For more than 10 years, we have focused on building a transparent, collaborative, adaptable and supportive environment with the State of Kansas, Members, Providers, the Medicaid Fiscal Agent and other stakeholders to promote improved health care service delivery and Member outcomes (per **Scope of Services 7.9.3/13.9.3.A.8**). We appreciate the leadership of the Kansas Department of Health and Environment (KDHE), the Kansas Department for Aging and Disability Services (KDADS), and the Department of Children and Families (DCF) in establishing a clear vision and a cooperative environment. Positive impact requires teamwork, and we routinely join with multiple stakeholders on projects, such as eligibility renewal efforts. As a testament to these partnerships, **we have earned a 4 out of 5 Star rating in NCQA's 2023 Health Plan Ratings, making us the top-rated Kansas MCO. We are the highest rated D-SNP and have achieved the highest P4P outcomes in Kansas. Further, 48% of KanCare Members choosing an MCO have chosen UnitedHealthcare, making us the most selected health plan.**

To achieve these results, we play the crucial role of convener, bringing together key stakeholders, connecting policy and implementation to align the objectives and results in interdependent, collaborative partnerships that support the Kansas health care ecosystem. Much like our approach to listening to our Members to drive our person-centered care, we listen to our State partners, Providers, Medicaid Fiscal Agent, fellow MCOs and the community to drive local and collaborative innovations that matter most to them. Our process is a continual loop where we engage and listen to our partners, act on what we hear, evaluate our approach for effectiveness, share the results and work to improve as part of the larger team serving KanCare Members.

In the following table, we provide specific examples demonstrating our collaboration, adaptability and supportiveness of the KanCare program. These examples are described in detail throughout our response. We strive to expand our collaborative approach in Kansas.

Select Examples of Collaboration, Adaptability and Supportiveness of KanCare Program		
State Agencies	▪ Member Eligibility Renewals ▪ STEPS Program	▪ Lead Levels Testing ▪ OneCare Kansas ▪ COVID-19 Response
Providers	▪ Alternative Payment Models ▪ Provider Education and Training	▪ Mental Health First Aid Training ▪ OneCare Kansas ▪ Catalyst Program
Fiscal Agent	▪ Kansas Modular Medicaid System (KMMS) Module 7 ▪ Provider Enrollment	▪ Member Enrollment
MCOs	▪ Kansas Association of Medicaid Health Plans (KAMHP)	▪ HEDIS® and Performance Improvement Project (PIP) ▪ Medicaid and Coffee
Community Partnerships	▪ Program Improvement Engagement and Community Investments	▪ COVID-19 Culturally Diverse Response
Partnership and Innovation	▪ Skills System ▪ Centralized Credentialing	▪ HOPE Foster Care Model ▪ Direct Service Workers

Collaborative, Adaptable and Supportive with Kansas State Medicaid Agencies

As a trusted advisor to KDHE, KDADS and DCF, we will continue supporting the attainment of the goals of KanCare and the State Medicaid agency. We are enthusiastic about the opportunity to offer our insight and lessons learned and collaborate with the State on system transformation and the success of KanCare. As a service-oriented organization, we aim to truly understand KanCare Members' unique needs, so that together we can improve population health and social outcomes. The following provides a few of the many examples where we have served as a partner to KDHE, KDADS and DCF.

Direct feedback from KDHE on our approach to partnering. "UnitedHealthcare is always engaged and responsive. They will pick up the phone when I call. They bring information to the table at meetings, and they are usually the first one to speak up when questions are presented."

– Annual State of Kansas Satisfaction Survey

Collaboration with the State on Member Post Public Health Emergency Renewal Effort

UnitedHealthcare partnered with KDHE, KDADS and DCF on its Post Public Health Emergency (PHE) renewal effort. In collaboration with the State, we worked with over 400 Provider groups, hospitals, health departments, home- and community-based services (HCBS) Providers and community organizations across the State to educate staff and provide educational materials about the importance of the Post PHE renewal. Our materials explained the process that a Member needed to follow to retain eligibility and how community partners support the State's renewal process.

SUPPORTING PROVIDERS

"Laura Canelos [UnitedHealthcare director of member engagement] has been absolutely amazing to work with during this Medicaid Eligibility Renewal process. UnitedHealthcare is the only MCO who is on top of this, and she has been an absolute asset to us during this time of KanCare unwinding. The information she has given us for this process has been so helpful."

– Julie Schott (Medical Reimbursement Specialist) Hutchinson Clinic

Medicaid Member files with renewal dates were distributed to Provider offices, creating an additional touchpoint for informing individuals of the need to renew eligibility. We produced customized Member reports for Providers to enable direct outreach to their Members on eligibility renewals. Community coalitions combined their data with our Member data to help us identify opportunities for targeted outreach via geographically based in-person field initiatives. We partnered with organizations to push educational inserts in utility bills; developed support videos in English and Spanish; and supported, via social media, education about eligibility renewals for all Kansas Medicaid Members.

Implementation of STEPS Program

UnitedHealthcare provided technical expertise to KDHE to deploy the Supports and Training for Employing People Successfully (STEPS) pilot program through Public Partnerships LLC, a contracted electronic visit verification (EVV) Provider, in July 2021. EVV is a telephone and computer-based solution that electronically verifies in-home service visits. We hired two designated STEPS care coordinators and a STEPS program manager who led the rollout of the program's processes, and, leveraging our Provider partners, we identified and recruited Members into the program for all three incumbent KanCare MCOs. Our STEPS staff provided education and eligibility criteria to the LTSS health plan staff. As a result, **53% of the STEPS enrollment and 79% of the referrals are UnitedHealthcare Members**, demonstrating our commitment to the program's success. Our STEPS program manager and care coordinators continue to actively monitor this program's success through growing enrollment and referrals.

Blood Lead Level Testing

UnitedHealthcare supports KDHE's Kansas Childhood Lead Poisoning Prevention Program to increase awareness of the risk of childhood lead poisoning and promote prevention strategies to Members, their families and stakeholders in the local communities. Our care coordinators outreach within one business day of all lead screening referrals to engage with the family and provide education. We assign a Community Health Worker (CHW) for timely follow-up of ongoing lead testing and to assess and address any potential SDOH barriers to completing a lead test such as transportation to the site. We participate in the Public Health and Medicaid Advisory Workgroup in Topeka and other work groups to collaborate to remove barriers, such as transportation and education, to lead testing. Through these work groups, we make connections, work to understand the full Member experience and look for opportunities and partnerships (including partnerships with local health departments) that will improve outcomes across the state. These conversations improved the lead level testing rates across Kansas. Based on our experience in reporting year 2022, UnitedHealthcare achieved greater than the 25th percentile for Lead Screening in Children (LSC) in KanCare based on Quality Compass national Medicaid data with a goal to improve to meet the updated 33rd percentile during the next KanCare contract period.

Collaborative, Adaptable and Supportive with Kansas Medicaid Providers

To be successful with our Provider partners, we truly listen and incorporate their feedback, and we address concerns directly and respond by detailing the support and benefits we offer. We support Providers through Kansas Medical Assistance Program (KMAP) enrollment, credentialing and contracting to enable a positive experience and connect the Provider with a Provider advocate who will support them.

Our strong service orientation and quality-based performance incentives engage Providers as our trusted partners. We support and reward Providers committed to caring for complex populations, transforming care delivery and engaging in performance-based programs and reimbursement.

Alternative Payment Models

We are committed to maximizing value throughout the health care system by fostering collaborative partnerships with Providers, such as Windsor Place. We design alternative payment models (APMs) that reflect Providers' current capacity for risk. Just as Kansas' diverse regions have different pressing health challenges such as smoking, obesity and diabetes, Providers are at varying levels of capacity and readiness to manage value-based purchasing (VBP) programs. To support Provider success, we help Providers understand how to effectively manage patient care in a value-based model using a graduated, modular suite of VBP tools, including data and reporting analytics capabilities. This support enables Providers to advance along the continuum of payment programs at their pace and in a way that promotes engagement and alignment. This approach has allowed us to create unique agreements such as our VBP with New Birth Company, a freestanding birth center. In addition, our team's active engagement and outreach to Providers has **increased participation in our Community Plan Primary Care Professional Incentive Program (CP-PCPi) by 300%.**

LETTER OF SUPPORT

"Windsor Place At-Home Care has partnered with UnitedHealthcare on several progressive and innovative initiatives. Those include providing remote patient monitoring as a 'value-added' or 'in lieu of' benefit for their non-HCBS [frail elderly] Members. They have done this for hundreds of their Members, allowing these folks to remain in their homes while reducing acute episodes and claims."

– Monte Coffman
Windsor Place

Improving Provider Experience Through Engagement and Training

Our team engages with Providers at conferences and other community forums throughout the year to gain purposeful and actionable feedback. For example, our team often hears feedback related to the importance of first-time claims resolution, billing trainings, and online tools and the ease of connecting with a live staff member for support. **In 2023, we attended 24 Provider conferences and spoke with over 6,000 Providers. We also completed over 23,000 direct Provider touchpoints.** The local Provider advocate team actively supports KanCare Providers by answering questions, promptly resolving concerns and conducting personal outreach and education. Based on feedback from Providers, we recently redesigned the Provider survey with the help of other KanCare MCOs. The new survey has simplified the survey for Providers yielding improved participation, which gives us another way to obtain and act on Provider feedback. This includes our team engaging in both larger training forums and one-on-one support such as lunch-and-learns.

Sharing tools and resources that support health literacy in a culturally appropriate manner is a critical component of our engagement strategy. We accomplish this goal by hosting Provider-centric training and providing incentives to complete relevant courses about UnitedHealthcare's operations, changes in the health care landscape and the population we serve. We collaborate with Providers on cultural competency training to help them better assess the cultural and social needs of Members during service delivery, and through providing more health-literate and culturally appropriate communications to Members.

Our Provider advocates coordinate and engage Providers, sharing information about State requirements and UnitedHealthcare through annual Provider expos, monthly Provider education town hall meetings, regular operations meetings, free Provider continuing education events, industry organization support, online self-service tools and in-person and community support. These open engagements promote clear dialogue with Providers to learn their needs and help reduce barriers to care.

Through our Provider training program, we provide outreach materials, including our **Kansas Provider Manual,** which is a comprehensive administrative resource for all Kansas physicians, health care professionals, ancillary Providers and facility staff; our **Provider Quick Reference Grid,** which is a one-page reference table highlighting key and commonly used tools; and our **Provider Advocate Presentation,** which is used to introduce Kansas Providers to their assigned Provider advocate and instruct Providers on collaborating with our Provider advocates.

LETTER OF SUPPORT

"UnitedHealthcare has supported us in providing person-centric care and meeting each individual where they are in respect to their unique needs. We look forward to continuing to impact individuals in Southeast Kansas through future innovative strategies involving [nonemergency medical transportation] and other potential value propositions."

– Jason Wesco

Community Health Center of Southeast Kansas

LETTER OF SUPPORT

"We are grateful for the types of partnerships and assistance provided by UnitedHealthcare staff. We have collaboratively worked to impact our larger population through data and knowledge sharing. Through our work with UnitedHealthcare, it is clear they put the Member first and are always seeking to make improvement to benefit their Members and community."

– Venus Lee

GraceMed

Community Mental Health First Aid Training

We have partnered with the National Council for Mental Wellbeing to enhance the mental health support we offer by providing our local team training and certification in the nationally recognized Mental Health First Aid (MHFA) program. Our certified MHFA trainers have actively engaged community-based organizations (CBOs) such as El Centro and the Kansas City Indian Center, and clinical partners like Vibrant Health and Samuel U. Rodgers, to bring this invaluable, evidence-based training resource to our communities to equip them with the skills to identify, understand and respond to signs of mental health and substance use challenges in both English and Spanish. For the past **four years, our trainers have conducted MHFA classes in schools, clinics, public libraries and even within the women's correctional facility** in collaboration with the Kansas Department of Corrections. We aim to expand our MHFA offerings further and reach first responders, barbershops, beauty schools and rural communities where mental health support is scarce to empower Members to actively engage in their health care and achieve personal health-related goals by teaching them how to identify, understand and respond to mental health and substance use challenges.

Collaboration with the Implementation of the OneCare Kansas Program

The OneCare Kansas program launched on April 1, 2020. Leading up to the launch, UnitedHealthcare participated in implementation planning meetings with the State, other MCOs and Providers to prepare for the program. Once the program launched, we participated in weekly

implementation calls with all program participants. **Only UnitedHealthcare offered a dedicated employee to manage all aspects of the program.** Providers benefited by having a dedicated Provider relations program manager to work with, as it simplified and expedited their onboarding experience. All Provider applications and program forms were processed by that program manager.

During this implementation, UnitedHealthcare demonstrated innovation and collaboration by addressing the low enrollment response of the initial OneCare Kansas program invitations. UnitedHealthcare proposed to those participating in the program that each plan provide lists of eligible Members to OneCare Providers to assist them with identifying their Members who were eligible and to increase enrollment. In addition, we trained Providers and gave them access, with appropriate consents, to the Population Health Dashboard in CommunityCare, our population health software, which provides information they need to improve care coordination. Providers could see health data for their patients, including their assigned care coordinator and PCP information. We focused on open communications concerning Member care between our care coordinators and OneCare coordinators.

UnitedHealthcare Catalyst™ with Samuel U. Rodgers

UnitedHealthcare Catalyst is a distinctive community integration model that uses a collaboration of health care and community partners to address health disparities. It aligns and expands community capacity to improve health outcomes for **all individuals** in a certain geographic area. To reduce disparities, Catalyst combines detailed community health data analysis and community voices to address the highest-priority health challenges. Our Catalyst program convened the Samuel U. Rodgers Health Center and a local CBO, Northland HealthCare Access, to improve maternal and infant health by providing perinatal case management and addressing underlying SDOH. UnitedHealthcare's pregnant KanCare Members at Samuel U. Rodgers are eligible for this intervention. **Initial results for participants in this program have seen a 30% increase in BH and dental care for obstetrics patients, a 3.2% improvement in full-term births and a 90% improvement in Members attending post-natal care appointments for mother and baby.**

Collaborative, Adaptable and Supportive with Gainwell

UnitedHealthcare understands the importance of collaborating with the Medicaid Fiscal Agent, currently Gainwell, to make sure information related to Members, Providers, claims and encounters is produced, reported and maintained correctly. Our approach is one of sharing information and aligning on the ultimate goal of accurate and efficient claims payment.

KMMS Module 7 Implementation

In 2020, there was a significant transition of the Kansas Modular Medicaid System (KMMS) to Module 7. Intensive planning, cooperation, adaptability and testing was necessary. During this implementation, we carefully coordinated efforts across KDHE, KDADS and DCF systems, including the Member eligibility system with all components of Member data, Fiserv (Kansas' EVV system) and the other MCOs. As part of the conversion, UnitedHealthcare took accountability for training and enabling Providers and other users to effectively use the KMMS system to accommodate the State's preferred data interchange format. UnitedHealthcare's systems team partnered with Gainwell to adapt our system and find ways to make the transition successful. We actively addressed challenges to support the State's goal of successfully implementing KMMS Module 7.

Provider Enrollment

We collaborate with Gainwell to support Provider enrollment through the KMAP Provider Enrollment Portal. Working directly with Gainwell Provider enrollment staff, we help Providers complete their KMAP enrollment, check status of enrollment and close the loop on enrollment status. We have improved the Provider experience with enrollment, credentialing and contracting to provide Medicaid services in Kansas by taking the burden off the Provider to track their enrollment through the process through our direct partnership with Gainwell's Customer Service Manager and Provider Enrollment Supervisor. Providers often do not know who to call, us or Gainwell, to check their enrollment status. With our collaboration with Gainwell, we are able to exchange data and resolve Provider enrollment issues regardless of who received the initial call.

Member Enrollment

Similarly, we partner with Gainwell to support Member enrollment questions. If a Member calls Gainwell with an issue that should come us, we have developed a secure process where Gainwell customer service can push the issues through KMMS Service Now to send the Member issue directly to us to resolve. The process includes a closed-loop process where we will notify Gainwell when and how we resolved the Member issue. This direct process has enabled Member issues to be resolved quickly, which has helped Member satisfaction.

Collaborative, Adaptable, and Supportive with Other MCOs

Kansas Association of Medicaid Health Plans

UnitedHealthcare is actively engaged with the Kansas Association of Medicaid Health Plans (KAMHP), an association that provides a venue for MCO cross-collaboration to best serve Kansas Medicaid Members. The KAMHP board consists of representatives from all three KanCare Health Plans along with external counsel to monitor all meetings. Our director of external affairs, Wade Hapgood, has served as the president of the board since 2019. A key output of the KAMHP is the value of information that tells the story and impact of managed care.

The KAMHP has evolved over the years to support the KanCare vision by forming deeper, more meaningful partnerships between MCOs. During monthly and ad hoc meetings, the association works through clinical policy challenges, best practices, operational improvements and sponsorship opportunities. A recent action by the KAMHP was the joint sponsorship of TOPSoccer, an adaptive soccer program for Topeka-based children with disabilities. We aim to expand its success across the state.

HEDIS

The quality teams for the three MCOs frequently partner on the development of quality measures to advance effectiveness and reach a larger Member base. Our quality team collaborated with other quality teams and the State to provide recommendations on future pay for performance (P4P) measures by assembling a slate of recommended HEDIS measures, Uniform Data Set measures and State initiatives documented in the Healthy Kansans 2030 Report.

Performance Improvement Project

UnitedHealthcare worked collaboratively with two incumbent MCOs to execute the COVID-19 performance improvement project (PIP) through a combination of Provider, Member and community-focused interventions to increase vaccination rates for KanCare Members. While each MCO was responsible for their own direct Member outreach though mail, email, text and phone, all three worked together to create Member community events to increase vaccination

rates. We led the community event strategy, working closely with State partners, community organizations and the other MCOs to encourage Members to attend by offering incentives and bringing "taco" food trucks to the events. One example is the Wyandotte County event in December 2021, where **475 KanCare Members received their COVID-19 vaccination, of which 210 (44%) were UnitedHealthcare Members.** Another strategy was to increase vaccination through OneCare Kansas (OCK), where UnitedHealthcare has **the highest outcome of 64.7% of Members enrolled in OCK receiving a vaccination by Sept. 30, 2022**.

Medicaid and Coffee

UnitedHealthcare orchestrated and hosted, alongside other MCOs, "Medicaid and Coffee" educational sessions at the State Capitol to provide legislators context and data about the role of Medicaid Managed Care in supporting populations, including the most vulnerable. We will continue this high level of collaboration as we build out our strategy with the State and other stakeholders on important and progressive system efforts, such as our updated commitment to community reinvestment.

Collaborative, Adaptable and Supportive with Community Partners

UnitedHealthcare's Improvement Engagement and Community Investments

We are actively engaged in key stakeholder groups, committees, coalitions, collaboratives and task forces focused on reducing health disparities and bringing innovative health solutions to Kansans. We use what we learn from our engagement to drive how we can invest and support programs, initiatives and community partners to provide direct and wraparound services to Members to improve health outcomes. UnitedHealthcare **has invested over $7.1 million since 2020 in support of Kansas communities, of which $4.3 million was direct support during the COVID-19 PHE, including $1 million to FQHCs for building capacity**. UnitedHealthcare was appointed as a pass-through payer for the $30 billion emergency relief funds for public health and social service Providers as part of the CARES Act. A total of $50 million was paid out to 3,795 Kansas Providers through this effort.

COVID-19 Culturally Diverse Response

UnitedHealthcare provided direct support to the community and Kansas Medicaid Members during the pandemic crisis period. In the uncertain early days of the pandemic, we stepped up to help deliver unified messaging to Members. UnitedHealthcare took the initiative to craft easy-to-read, written Member communications and work with the other MCOs and the State to gain agreement, approval, and then wide dissemination of this information.

UnitedHealthcare's COVID-19 Assistance

"The impact this effort had on the community is immeasurable and was only due to the tireless and selfless efforts made by UnitedHealthcare, Genesis Family Health, the Liberal Area Coalition for Families, Seward County United Way and the many, many volunteers and individuals who dedicated their time, energy and efforts to coordinate this event."

"Liberal has been truly blessed to be filled by amazing, hard-working individuals and organizations that collaborated and came together to help people in their greatest time of need."

– Quotes from individuals receiving COVID-19 aid

In addition, UnitedHealthcare collaborated with KDHE and other MCOs to implement vaccination events. Our team hosted, supported and attended more than 50 vaccination events, providing Member incentives, food truck meal vouchers, COVID-19 card pouches and culturally

appropriate educational materials to individuals getting vaccinated. Bilingual UnitedHealthcare staff provided interpretation services.

Leveraging Experience from Programs Similar to KanCare

We look forward to continuing our support for KanCare by leveraging programs and best practices from our other Medicaid states. The following are specific examples we are evaluating for Kansas.

UnitedHealthcare's "Skills System" Used in Tennessee and Virginia

A program that we will offer to bring to Kansas is the Skills System initiative that was launched in Tennessee and Virginia to support the continued development of IDD expertise within the BH system. The Skills System program trains Community Mental Health Centers/Certified Community Behavioral Health Clinics (CMHCs/CCBHCs) to offer effective clinical treatment to people with mental/behavioral health needs and IDD. Skills System provides accessible, tangible emotion regulation strategies to individuals with IDD and the members of their support systems, such as family caregivers and paid staff. Skills System tools help all involved (clients, staff and family members) improve their self-regulation and co-regulation capacities. In Tennessee, UnitedHealthcare convened clinicians and agencies throughout the state that included 65 community IDD Providers and individual therapists for training, which built their competencies with IDD individuals who experience co-occurring mental health conditions, thereby improving the Member experience.

Centralized Credentialing

We understand the State may be exploring the future operationalization of centralized credentialing to standardize Provider enrollment processes, and we can bring relevant experience from Arizona and Texas. UnitedHealthcare was part of a collaborative effort organized through the Arizona Association of Health Plans (AzAHP) to reduce the burden of credentialing placed on Arizona physicians. We participated in the development and deployment of a statewide credentialing alliance and worked with other state Medicaid partners as a Member of the AzAHP. This effort aligned credentialing cycles across Arizona Medicaid plans, reduced duplication of efforts and provided for administrative simplification. In addition, in April 2018, our credentialing team implemented processes in conjunction with the Texas Association of Health Plans to implement centralized credentialing for Providers. The credentialing verification organization (CVO) is used for Provider credentialing and recredentialing for Texas Medicaid Providers and delivers a streamlined approach for Providers participating in the Medicaid program with other MCOs. We collaborated with the chosen vendor, Aperture, to achieve a seamless implementation of this new CVO process.

Specialized Model for Foster Populations

We are committed to providing specialized programs tailored to the unique needs of the populations we serve. For example, based on our national experience, we have developed and continue to refine the components of our program specifically for youth in foster populations promoting health outcomes. Through our Medicaid Managed Care contracts, we support:

- Over 41,000 youth in 21 states who are in foster care or receiving adoptive assistance
- Over 73,000 children who have complex health care needs in 25 states

We manage provision of physical health, behavioral health, long-term care and social services for children and youth in every form of state custody and all types of settings and levels of care. Tailoring this knowledge and experience to Kansas will support the KanCare vision of improving quality of life through connected care coordination, specialized Providers and caregiver support to achieve placement stability and reduce out-of-home placement rates.

Direct Care Workers

Combining what we know in Kansas with our national experience, we commit to creating a cross-MCO program focused on attracting, recruiting and retaining direct care workers (DCWs) similar to our work in promoting CHWs. UnitedHealthcare funded a CHW training program for the State of Kansas in Wyandotte County, enabling it to become one of the largest community-based CHW programs. In addition, we offered the following data tools:

- **Workforce development dashboards** – Built from Member-reported SDOH and Provider Z code data (which tracks the social, economic and environmental determinants known to affect health-related outcomes), which provides teams with data to highlight unmet needs
- **Heat maps** – Flags Members with unmet needs by geographic area so that specific partnerships can be developed

We will leverage this experience and these assets to collaborate with the other KanCare MCOs to form a unified marketing and recruitment effort to attract and recruit HCBS workers into the workforce. We envision funding shared recruitment staff who will direct DCWs toward the HCBS staffing agencies. We will hire a marketing firm to deploy both standard marketing and social media campaigns that will work in tandem with the shared recruitment staff to achieve maximum saturation. In addition, we will focus on specific trainings that will improve recruitment and retention.

A Proven Partner in Kansas

Our transparent, collaborative, adaptable and supportive approach to our business is truly embedded in our culture of humility and partnership. As a trusted partner to the State, we focus on making KanCare and the State Medicaid agency successful. We are enthusiastic about the opportunity to combine our high performance in Kansas with our national experience as we work with KDHE, KDADS and DCF toward system transformation and the success of KanCare. We are a service-oriented organization, which guides our understanding of KanCare Members' unique needs. This mission drives us to improve health and social outcomes one Member at a time.

Member Experience (Tab 7b)

Fostering Independence and Healthy Living for Adults with Disabilities

People with a disability are more likely to report fair or poor health and to experience social isolation, but with the right supports, they can thrive in their communities. We provided a $300,000 grant to Inclusion Connections' BelongKC project to build a new supportive living campus. The project includes residential apartments, job training and activities to help adults with a disability live fulfilling, engaged and healthy lives.

Kansans United

United Healthcare Community Plan

Member Experience

4. Describe the bidder's approach to encouraging and engaging KanCare Members to actively participate in their health care and meet their personally-defined health and wellness goals and cross service system needs. Provide an example of a strategy the bidder has successfully used in a program similar to KanCare, including the impact of the approach on outcomes.

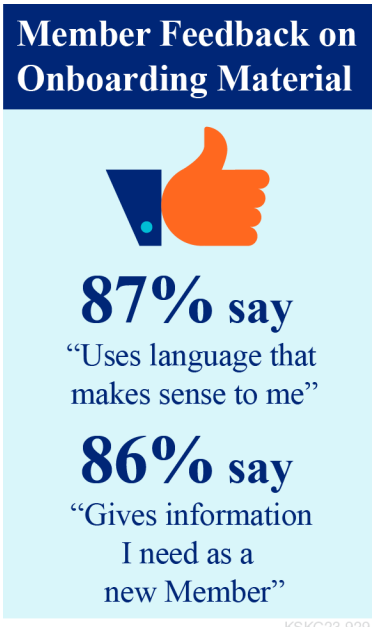
Encouraging and Engaging Active Participation of KanCare Members

UnitedHealthcare is committed to actively engaging our Members in their health journey to meet their personally defined health goals. From the moment they enroll, we engage Members through our robust onboarding experience, which provides key information about their benefits, connects them with Providers and offers multiple communication channels based on preference — all to help Members understand how to engage in their health care and support them in meeting their personal health and wellness goals. We welcome new Members through calls, traditional mail and digital tools and support active engagement and goal setting. Our approach is tailored to individual needs, leveraging our deep partnerships with community-based organizations (CBOs) and Providers to support their health and wellness goals and address social determinants of health (SDOH). We support Members by:

- Welcoming Members to promote active engagement in their health care
- Providing digital tools to support active engagement and goal setting
- Supporting Member-specific goals through active engagement
- Investing in Kansas to improve engagement and support Members' health goals
- Addressing cross-system service needs (SDOH)

Welcoming Members to Promote Active Engagement in Their Health Care

We engage our Members immediately upon enrollment through our robust onboarding experience, which gives Members key information about their benefits, how to find Providers and how to connect with UnitedHealthcare (e.g., through our Member portal, the UnitedHealthcare mobile app, member services center, community locations) in a simple and appealing way and in their preferred digital, mail, in-person or telephonic modality. Helping newly enrolled Members understand how to initially engage in their health care journey, we support them in developing and meeting their personally defined health and wellness goals.



Welcoming New Members Digitally

Upon notification and receipt of an email address from the State, we send a welcome email series to new and re-enrolled Members to promote active engagement in their health care. The series includes a *Getting Started* video, instructions for registering on our Member portal and mobile app, access to additional materials, support through our member call center and helplines and educational resources for primary care engagement. We monitor email engagement and respond to email questions or requests within one business day. Once registered, Members can opt in to receive personalized emails, such as annual flu vaccine reminders, or review their plan details, benefit notifications or to get help finding Providers and [redacted]

[redacted] Understanding that 95% of our national Medicaid Members have a smartphone they use to access the internet, and 61% prefer to access health plan information and benefits through the website or mobile app, we developed these digital tools and, as of December 2023, **our mobile app is ranked number two of all medical apps within the Apple App Store — leading our industry — and has been reviewed over 227,000 times, earning 4.7 Stars out of 5.**

Welcoming New Members by Mail

Within 10 days of enrollment, we mail each Member a welcome packet in their preferred language (English, Spanish and other languages to meet individual Member needs). The packet includes their ID card and a *Getting Started Guide* that provides information needed by new or re-enrolled Members, including instructions for selecting a PCP and completing a Health Screening Tool (HST). It includes details on requesting auxiliary aids or translation services for Provider appointments — particularly helpful in regions with Spanish-speaking populations.

Welcoming New Members Telephonically

HST Performance

In Kansas, we have achieved a **market-leading 91% successful HST completion rate** for Members successfully reached.

Providing a warm welcome to new Members and ensuring they have a seamless experience is the primary objective of our Hospitality Assessment and Reminder Center (HARC). Because health care requires an individualized approach, within 10 days of enrollment, our HARC team contacts new Members to learn more about their health status and provide customized support. During these welcome calls, our dedicated team proactively engages with Members, guiding them through the HST and works to understand their unique health care goals. To enhance the Member experience, our HARC team is equipped with language translation resources, offering support in over 240 languages so Members can effectively engage in the health screening process. Within the first 10 days, they make multiple outbound call attempts to Members, at different times of day, using language translation resources to meet the needs of our diverse Member population. Throughout the process, our team applies motivational interviewing techniques to make sure Members are engaged and comfortable. In addition, Members receive a $10 incentive each year for completing the assessment. If an additional assessment is required, our comprehensive care model enables prompt referral and support. For those who prefer nondigital engagement, our HARC team assists with our person-centered approach offering multiple ways to complete the HST, including phone, online and paper copies in multiple languages. Our goal is to prioritize our Members' health needs and provide personalized care coordination each step of the way.

Providing Digital Tools to Support Active Engagement and Goal Setting

To empower Kansans to achieve their personal health and wellness goals, and understanding the preference for digital content, we have made substantial investments in promoting Member health through our digital experience. Using data such as claims and State-provided information, we create a personalized digital experience for each Member, addressing their individual health requirements and diverse needs. For instance, pregnant or postpartum Members can easily manage their care through our [redacted] As a result, **our digital engagement has surged by 295%, mobile app logins have increased by 533% and Member satisfaction has risen by**

nearly 30% year-to-date. The following examples outline our digital experience enhancements that support our Members' health journey:

- **Whole Health Tracker:** We help Members set and achieve their health care goals through our Member portal's Whole Health Tracker, which provides an interactive platform where Members can identify their goals, interventions and methods for self-managing their health. In addition, our *Wellness Wheel and Toolkit* offers a user-friendly means for Members to track their progress in their wellness journey, creating a comprehensive picture of their strengths and uncovering avenues to move toward their desired life.

- **Doctor Chat:** Our Doctor Chat service enables Members to chat with a doctor 24 hours a day, seven days a week — at no cost — using the Doctor Chat app on a phone or tablet or online. Instead of waiting for a doctor's appointment to get questions sucanswered, Members can use Doctor Chat to get answers to medical questions within seconds from doctors who are licensed to practice across the United States and can prescribe some medications when necessary. Typical topics for Doctor Chat visits include general health

questions, where to receive care, urgent care, mental health (anxiety, depression, stress, insomnia), chronic care and prevention and women's health. Members using Doctor Chat report a **39% emergency department diversion rate and a 93% program satisfaction rate.**

Supporting Member-Specific Goals Through Active Engagement

To comprehensively support our Members in achieving their health-related goals, even beyond the traditional health care system, we seamlessly connect them to a wide range of comprehensive resources, including transportation, educational support, trauma-informed care management and other vital services. Our goal is to help Members navigate the complexities of the health care system, access necessary services and ultimately achieve their desired level of health and well-being. For example, we actively support Members' independent living by connecting them with employment opportunities that can provide sustainable income for them and their families — Kansans serving and supporting one another within their communities.

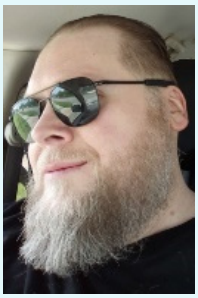
Supporting Person-Centered Goals for Healthier, Independent Living

For Members actively enrolled in our care coordination services, our person-centered approach prioritizes and fosters positive, health-related behavior changes, enhances Members' overall care experience and empowers Members to take charge of their health journey. We support Members' self-determination and independence by recognizing that Members are central to the care planning process. To begin this journey, we conduct a series of comprehensive assessments to capture Member needs and goals for the future. Our designated care coordinator works closely with the Member, along with any individuals the Member has chosen, to complete assessments and develop a personalized plan of action. Whether it is the home- and community-based services (HCBS) plan or the non-HCBS plan of service, this document serves as a roadmap, clearly defining the Member's health and wellness goals. According to our 2023 Member satisfaction survey, **Members enrolled in an HCBS waiver reported a 97% satisfaction rate with their UnitedHealthcare care coordinator and a 96.9% satisfaction rate with their HCBS.** By aligning our efforts with the Member's desires, we provide a truly person-centered approach that promotes overall well-being and satisfaction.

Supporting Behavioral Health Goals to Improve Overall Well-Being

Members enrolled in our care management programs receive additional benefits such as our Wellness Recovery Action Plan (WRAP), a printable online resource that addresses physical health, mental health and life-related concerns, to guide Members on their wellness journey. We have recently begun providing WRAP workbooks to Members with serious mental illness, serious emotional disturbance or substance use disorders to help them maintain their well-being by providing a wellness toolbox filled with simple, safe ideas to promote positivity and resilience. The WRAP guides Members through self-reflection and self-care, enabling them to identify what they are like at their best, establish daily wellness practices, recognize triggers that may upset them, develop strategies to cope with challenges and have a plan in place for crisis situations. It provides guidance on recovery and self-care after a crisis has ended, aiding Members in restoring their overall wellness and achieving health-related goals.

Lonnie: A Lifesaving Success

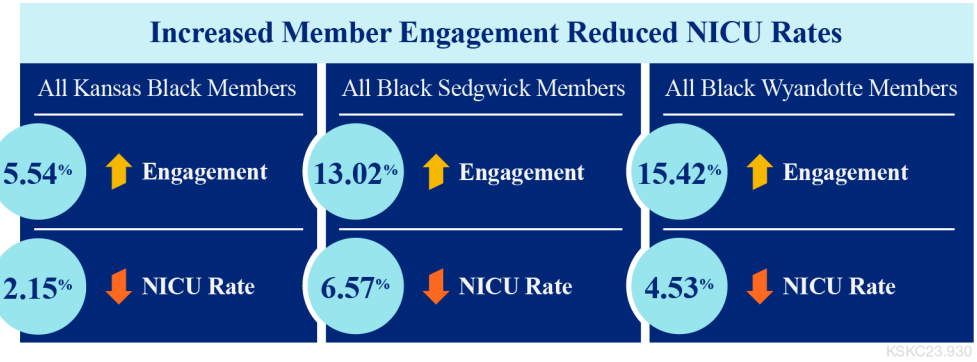


Our Member, Lonnie, was facing a dire situation, feeling hopeless, living without water, heat or gas and suffering from sleep apnea and mobility concerns. While we were addressing his critical health and wellness needs and housing and utilities issues, we secured a hotel room for him and assigned him a care coordinator, who identified that Lonnie could benefit from enrolling in a Dual Special Needs Plan (D-SNP), provided education and connected him to a D-SNP agent to complete the sign-up process. Our Community Health Workers (CHWs) supported him, including getting him transportation, finding Providers to help him with his feelings of isolation and lack of self-confidence and assisting him with completing the online Affordable Connectivity Program application for internet service. Helping him define a goal of becoming independent, this support motivated him to sign up for classes on gardening and how to generate income working at home — important steps toward achieving his goal. They helped him to get nutritional counseling at a weight loss center and acquire a bariatric rolling walker, which were key efforts toward becoming independent again. He has reported that he is going back to church and looking forward to making friends.

Supporting Goals for Improving Maternal and Infant Health

Our Healthy First Steps (HFS) program promotes the patient-Provider relationship and active engagement in care. Enrolled pregnant and postpartum Members receive assistance setting and meeting their personally defined health-related goals. The HFS program provides comprehensive guidance and assistance for the well-being of both mother and baby. Our dedicated HFS nurses and CHWs collaborate with Members to address various needs, including doula support, selecting a doctor or midwife for delivery, selecting a PCP for the baby, and family planning. Our team helps schedule and arrange transportation for visits and exams and connect Members with community resources such as Women, Infants, and Children (WIC).

Figure 4-2. Our Increased Member Engagement Reduced NICU Rates



Through the HFS website, Members can access a checklist of helpful questions to ask their doctor during pregnancy and after birth, track informative markers of their baby's growth and explore a library of topics relevant to pregnancy, birth and more. Through the Babyscripts rewards program, Members can obtain gift cards for $25, and can earn up to $75 promoting their engagement and incentivizing their pregnancy-related goals.

Our data consistently demonstrates the positive impact of our HFS team. Establishing trusting relationships and fostering active engagement, our HFS team effectively identifies and addresses barriers to prenatal and postpartum care. This level of personalized support leads to better outcomes for moms and their babies, ultimately helping moms meet their personally defined health-related goals. The figure demonstrates how increased Member engagement with our maternal care coordination program correlates to improved health outcomes for Black KanCare Members — in this example, decreased NICU rates. Our evidence-based care enables the well-being of both moms and their newborns.

Encouraging Healthy Behaviors to Support Member Goals

To promote active Member engagement and support them in achieving their health-related goals, we offer a range of incentives and rewards throughout Members' health care journeys. Encouraging healthier choices and engagement with preventive care, these rewards support healthier Members. Following are two examples of rewards we offer our Members:

- **Healthy Rewards:** Our rewards program offers Members the opportunity to earn debit card rewards for completing important health-related tasks. Member rewards range from $10 to $75 annually. Once a Member completes a qualifying activity, they receive a reward debit card in the mail, or the balance is added to their existing card. Members can earn rewards by completing the HST, attending annual checkups for children aged 3 to 17 and can be invited to earn rewards for specific health activities. The number of unique Members receiving rewards for completing specific health tasks has **increased by 388% from 2022 through year-to-date 2023. In addition, the health screening reward has experienced an increase of 22% during the same period.**
- **Babyscripts:** Our comprehensive digital maternity engagement, education and incentive program, Babyscripts, empowers Members who are expecting or have recently become parents to actively engage in their health care journey during pregnancy and beyond. Through a user-friendly app, Members receive daily educational content on various aspects of pregnancy, childbirth and postpartum care so they can make informed decisions aligned with their health goals. In-depth resources empower Members to explore specific topics relevant to their health goals, while incentives such as gift cards motivate them to stay consistent with health care appointments. Moreover, the program helps Members connect with other expectant parents, offering motivation, encouragement and a network of support. Among program participants, **82% reported feeling more knowledgeable about their pregnancy journey, and adherence to postpartum visits at 30 days increased by 127%.**

Rewarding Providers for Improving Engagement and Supporting Members' Health Goals

Because Providers play a crucial role in helping Members achieve their personally defined health-related goals, we implemented a comprehensive Provider incentive program to encourage network Providers to empower Members to actively participate in their health care. This collaborative approach gives our Members personalized support to reach their health goals and ultimately lead healthier, more fulfilling lives. For example, Our **Outpatient Shared Savings (OPSS) program** focuses on improving active Member engagement in care, particularly those recently discharged from inpatient behavioral health hospitals. Through our Point of Care Assist® tool, Providers receive near real-time alerts when Members are admitted or discharged from an inpatient or emergency department visit. When equipped with this crucial information, Providers can prioritize follow-up appointments and enable seamless continuity of care.

The most recent OPSS measurements in Kansas reveal a promising **6% increase in seven-day and a 10% increase in 30-day follow-up appointments. In addition, medication adherence has shown improvement of up to 6%** — outcomes that clearly demonstrate the OPSS program's positive impact in engaging and supporting Members in achieving their health goals. As we continue to innovate and collaborate with Providers, we are confident we can drive positive change and support Member health goals by creating a health care ecosystem that prioritizes proactive care, personalized support and improved overall well-being.

Sydni — Career Success Through Community-Based Resources

Sydni, a Member with certified nursing assistant credentials, needed to attend a course through Allied Health Career and Training to gain certified medical assistant credentials, which would enable her to become licensed to dispense medication. Sydni and a UnitedHealthcare employment specialist reviewed our value-added benefit (VAB) of $200 and brainstormed the best way for her to use this benefit to achieve her goal. Aligning with her health goals, our staff provided information for Sydni to contact her local workforce center to ask about financial resources they might have to help cover the $729 cost of the course. She was beyond excited to discover the workforce center would cover the entire amount for her course, with UnitedHealthcare paying for her required books using our educational VAB. Sydni will soon finish her course and be able to move forward with her career. The increase in income will help lead her to holistic wellness. It will foster financial stability, promoting healthy living by making more nutritious food, regular health checkups and memberships to fitness centers more affordable. It will also enhance her social interactions by enabling her financially to participate in activities she enjoys and encouraging her overall personal growth. Sydni's success story exemplifies how we directly support our Members to achieve their health-related goals, empowering them to enhance their financial well-being and pursue a healthier and more fulfilling life.

Investing in Kansas: Improve Engagement, Support Members' Health Goals

We connect our Members to valuable community resources that help them achieve their personally defined health-related goals by building community capacity and collaborating with local organizations to integrate support for health-related needs into every Member engagement. Since 2022, our investment of over $7.1 million in CBOs and partnerships with Providers has allowed us to benefit from the expertise and insights of our local partners, enabling us to effectively tackle the distinctive health challenges experienced by our Members. We listen, learn and work together with communities to make sure our Members receive the comprehensive support they need to thrive and achieve their health goals.

American Heart Association (AHA)

Our collaboration with AHA actively strengthened and extended our partnership with the four Kansas tribes through food access and nutrition initiatives. This included expanding the Tribal Health Summit, piloting a Food as Medicine program, supporting an Indigenous communications consultant and fostering culturally sensitive partnerships, food systems and capacity-building efforts for American Indian tribes in Kansas.

We have established strategic partnerships with The Doula Network, the Community Health Council of Wyandotte County, and the Center for Research for Infant Birth and Survival. These collaborations support deployment of maternal CHWs and doulas in Sedgwick and Wyandotte counties — skilled professionals who provide culturally competent support, address unmet social needs and guide Members through their pregnancy journey.

Kansas Food Bank Warehouse

Through our partnership with the Kansas Food Bank Warehouse, **we have provided over 3.2 million meals to Kansans.**

Through our partnership with the National Council for Mental Wellbeing, we enhance the mental health support we offer by providing our local team training and certification in the nationally recognized Mental Health First Aid (MHFA) program. Our certified MHFA trainers have actively engaged CBOs such as El Centro and the Kansas City Indian Center and clinical partners like Vibrant Health and the Samuel U. Rodgers Health Center to bring this invaluable, evidence-based training resource to our communities to equip them with the skills to identify, understand and respond to signs of mental health and substance challenges and promote awareness and use of the 988 suicide and crisis lifeline. For the past four years, our trainers have conducted MHFA classes in schools, clinics, and public libraries and even within

the women's correctional facility in collaboration with the Kansas Department of Corrections. We will expand our MHFA offerings further and reach first responders, barbershops, beauty schools and rural communities where mental health support is scarce.

We engage Members through community wellness events and educational initiatives made possible through collaborative partnerships with faith leaders, schools, health departments, clinics and community organizations. Our outreach team's active participation and support in community events and gatherings improve Members' ability to actively engage in their health. These opportunities to share information and increase health literacy empower our Members and support their overall wellness so they are well informed about important topics such as Medicaid eligibility and the importance of preventive care. We educate them about the services offered by our VABs and provide any other relevant information. Our active presence in wellness events like baby showers, back-to-school fairs and wellness clinic days shows our commitment to helping our Members meet their health-related goals. **Since 2019, we have attended 1,184 events and reached out to 130,369 individuals,** providing information that equips them to take charge of their wellness journeys.

Addressing Cross-System Service Needs: Social Determinants of Health

We work hand in hand with our Members to identify their goals related to SDOH and our extensive network of community partnerships helps achieve them. Using platforms like the UnitedHealthcare Community Connector and Findhelp, electronic referrals and direct contact with community organizations, our member service advocates and care coordinators verify that Members' SDOH needs, such as housing assistance, WIC and access to homeless shelters, are met within their local community. We closely track the progress of referrals, following up with Members and updating their referral status. If a referral remains unresolved after 30 days, our system automatically reaches out to the Member for verification. If the need was met, the referral is marked complete. If not, our advocates proactively engage with the Member and collaborate with care coordinators to address outstanding needs. In Kansas, our SDOH navigators work with Members experiencing failed referrals until their needs are met. Actively addressing social needs and enabling seamless connections with CBOs, we prioritize our Members' overall wellness and engagement.

SDOH Referral Success

Year-to-date, our call center advocates have made 5,200 SDOH referrals, **successfully closing the loop for 92% of these Members, with 99% reporting met needs.**

Figure 4-3. Our Members Are Active Partners in Their Health

Further enhancing our community support, we enlist the help of CHWs or certified peer support specialists from local neighborhoods to enhance Member and community support. Playing a crucial role in identifying potential barriers that Members may face in accessing health care services, CHWs connect Members with services, supports and community resources, fostering a sense of ownership and active participation in their health journey. Making health care a collaborative effort helps ensure Members are not passive recipients of services but active partners in their well-being. We support their personally defined health and wellness goals and address their cross-service system needs.

Coordinating Cross-System Service Needs: Dually Eligible Members

For KanCare Members who are dually eligible, maneuvering within two complicated systems can be difficult and can, in many instances, lead to adverse outcomes such as a protracted nursing facility stay following an acute episode. As the market leader for D-SNP, with over 13,500 Members enrolled in our plan, we understand the importance of coordinating care for all dual eligible Members and integrating care for our Members who are dually enrolled — it is a fundamental role of a managed care organization to effectively address Members' goals and needs whether or not they are enrolled in our D-SNP. We are committed to coordinating services and removing barriers of care while improving health outcomes. By providing high-quality care coordinated across the delivery system, considering the Members' physical health, behavioral health and social needs, we support Kansans to age in their setting of choice.

Coordinating Cross-System Service Needs: Whole-Person Care

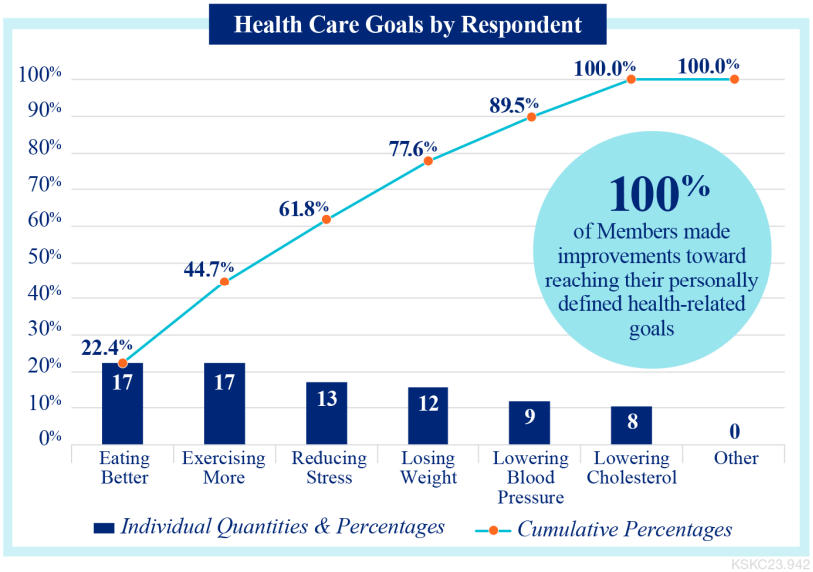
Our whole-person care that prioritizes our Members, their needs and health-related goals. Our interdisciplinary team (IDT) actively listens, advocates and provides unwavering support to those we serve. With a focus on person-centered, trauma-informed care, our primary goal is to empower and build resilience among our Members, leading to improved health outcomes. Through our integrated, equity-focused capabilities, we employ systematic screening to identify health and wellness opportunities for our Members. We then support them in developing their health-related goals and connect them to specialized programs built with local expertise to help them achieve those goals. Our comprehensive model addresses not only our Members' medical needs and goals but also their social needs and goals. From preventive care to intensive support and services for complex medical, behavioral health, dental, vision and pharmacy needs, our coordination spans the entire system to address their unique needs.

In Kansas, our integrated whole-person care model offers a continuum of services tailored to each Member's risks, needs and evidence-based interventions. We prioritize efficient identification of needs and work together with our Members to develop goals to resolve those needs. This approach ensures our Members are connected to the appropriate level of services on the continuum, promoting effective and streamlined care. By employing person-centered, culturally responsive strategies, we foster collaborative partnerships with Providers and community organizations, guaranteeing that our Members receive the highest quality of care and the necessary support to achieve their individual health and wellness goals. As a result, in 2022, we saw an **18% increase in controlling high blood pressure,** showing the positive impact of our interventions. In addition, **diabetic HbA1c levels decreased by 3.5%,** indicating improved management of diabetes within our program. Further, we saw an **8.7% improvement in pharmacotherapy management of COPD,** showing the effectiveness of our approach in addressing complex medical conditions.

An Example of Success: Our Partnership with Mount Calvary Church

Our work and partnership with Mount Calvary Church in Ohio shows our approach and methods for encouraging Members to actively engage in improving their wellness and meeting their health-related goals. We first identified Members' needs, focusing on the high prevalence of hypertension and disparities in outcomes for Black men in the Greater Akron area. We then sought an active partnership with a CBO that wanted to offer wellness services to the community, finding Mount Calvary, a local Akron church.

Figure 4-4. The Mount Calvary Church Program Improved Member Wellness for Personal Health Goals



We collaborated to develop, design and implement the program following the EAST framework (Easy, Attractive, Social and Timely) developed by the behavioral insights team. To understand community needs, resources and values, we conducted surveys to gain voice of the customer input, then developed and deployed education programs focused on nutrition, fitness, heart health and diabetes, along with specific classes for exercise and yoga. We used participant feedback to design the classes and to align considerations such as class date, time and location with EAST principles — easy with class times to meet participants' needs; attractive by engaging church leaders, including the pastor in the program; social with a positive peer group in the classroom; and timely by inviting Members when their community was launching a health promotion drive. After successfully completing two cohorts of classes, we monitored participation through run charts and conducted surveys to measure the impact of the program. The figure highlights positive results from each cohort, with **89.5% of engaged Members successfully achieving lower blood pressure levels** — aligning with our objective to reduce Black men's hypertension rates in the Akron area and supports participants' health-related goals.

UnitedHealthcare is dedicated to actively engaging KanCare Members in their health care to help them meet their personally defined health and wellness goals. Our robust onboarding experience provides key information and resources to support Members' understanding and engagement in their health care journey, while our multiple communication channels and digital tools [redacted] promote active engagement and goal setting. Further, we invest in CBOs and partnerships to address SDOH and support Members' overall well-being. Coordinating cross-system service needs and delivering whole-person care, we empower Members to lead healthier and more fulfilling lives, with success stories in areas such as maternal and infant health and community partnerships demonstrating how we improve engagement and support the health goals of KanCare Members.

Member Experience

5. Describe the bidder's approach to soliciting and reviewing feedback from KanCare Members and their families, and using this feedback to improve Member and family experience and the KanCare program.

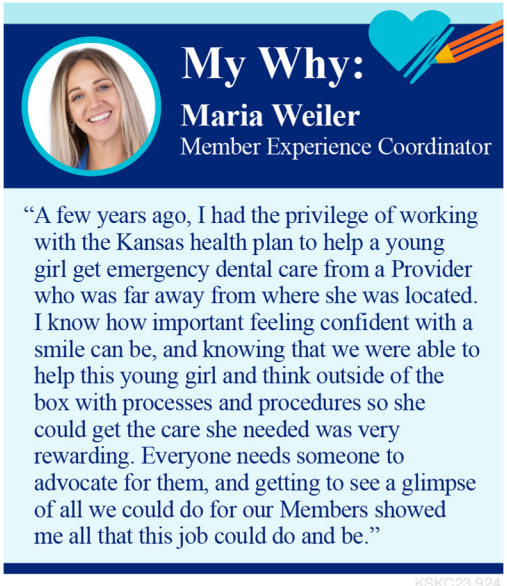
Soliciting feedback from our Members and acting while continually monitoring and modifying our approach enables us to make improvements that matter, resulting in **more Members selecting UnitedHealthcare in Kansas than any other managed care organization.** We take a compassionate approach to service. With every interaction, we ask how we can help our Members and their families and continually reassess and improve our benefits and services to meet their needs. Feedback from Members and their families guides the constant improvement of our programs and services, contributing directly to **our 2023 NCQA top-rated status in the KanCare program, including our receiving the top rating for Patient Experience (4 out of 5) and Satisfaction with Plan and Plan Services (4 out of 5).** Further, 48% of KanCare Members choosing a managed care plan have chosen UnitedHealthcare, making us by far the most selected plan.

In Kansas, we use our core capabilities of catalyzing connections and continuous improvement to effectively comply with **Scope of Services 7.9** and achieve the State's objective of enhancing Member experience and satisfaction through our Voice of the Member Loop (shown in the figure to the right):

- **Listen:** Be intentional about gathering input from Members and their families
- **Act and evaluate:** Develop solutions based on input and regularly measure effectiveness
- **Improve:** Using Act and Evaluate results, we look for ways to improve our services

Figure 5-1. UnitedHealthcare Voice of the Member Loop

Our approach is validated by the consistent feedback through our Voice of the Member Loop. Through both formal and informal feedback loops, we continually gather insights that demonstrate the effectiveness of our approach. For instance, **95% of surveyed UnitedHealthcare long-term services and supports (LTSS) Members expressed satisfaction with their health plan, while 98% reported satisfaction with their designated care coordinator**. At our core, we prioritize cultivating a culture of continuous improvement that is centered around the needs of Kansans. Through ongoing innovation and collaboration, we make a positive impact in our community and the lives of our Members.



How We Solicit and Listen to Feedback from KanCare Members and Families

Using our Voice of the Member Loop, we ask our Members for feedback, listening for recommendations through direct interactions and surveys. We leverage

that insight to develop strategies that enhance health outcomes and overall quality of life. We go beyond asking simple questions like "how was your interaction?" in our satisfaction surveys, actively seeking input from our Members on how we can better serve them. Our surveys delve deeper, exploring Member satisfaction with topics like community involvement, control over leisure activities and choice in living arrangements. Through these measures, we identify areas of optimization and opportunities to keep our Members independent and safe while obtaining market-leading quality outcomes. The table that follows lists the ways we use direct conversation to listen to Members.

Ways We Listen to Members Through Direct Feedback	
Day-to-Day Interactions	▪ Real-time member services call monitoring and feedback ▪ 214 designated care coordinators and CHWs serving Members ▪ Community outreach and events — since 2019, we have attended 1,184 events, attended by 130,369 individuals
Member Advisory Committee (MAC) Meetings	▪ Comprises LTSS, Behavioral Health, Temporary Assistance for Needy Families (TANF) and Children's Health Insurance Program (CHIP) Members and families statewide ▪ Members receive gift card reward for attending ▪ Meetings supported by peer support specialists, care coordinators, community outreach and local leadership ▪ Spanish interpreter attends and sometimes hosts a separate all-Spanish meeting ▪ Four meetings per year with at least two including health equity as an agenda topic ▪ Virtual meetings (via Zoom) have increased attendance from four to five families to 15 to 25 families and enabled more Members to join from rural and frontier counties
Member Listening Tours	▪ Annual statewide tour gathering Member input in urban, rural and frontier areas beyond required Member Advisory Committee (MAC) ▪ Support local community organizations and rural health clinics who host listening sessions and invite Members for feedback. These organizations provide us locations to host the meetings, invite the individuals they work with and often facilitate discussion as a third party, allowing us to listen to unbiased feedback ▪ The 2022 listening tour included 14 meetings statewide, with a Spanish-speaking session in Wichita ▪ One Member comment was, "Members appreciate being heard. They know that some things cannot change but the chance to have a voice means a lot"
"No Wrong Door" Policy	▪ Enables all staff members to assist Members any time by connecting them to the right resource ▪ All staff are trained to listen for any concerns and bring them to their managers for assistance, finding the right path toward resolution
Quality Assessment and	▪ Quality management strategy that drives quality improvement ▪ QAPI goal of improving Member health on key quality metrics

Ways We Listen to Members Through Direct Feedback	
Performance Improvement (QAPI)	▪ Results in the annual Quality Improvement Work Plan that includes process to monitor Member complaints, grievances and appeals and resolve Member concerns
Member Research Panels	▪ Our research panels gather feedback directly from Members with firsthand health care experience to shape and improve our offerings. Members share insights on digital preferences, engagement, Member materials, value-added benefits and identify opportunities they have experienced to improve their health care journey ▪ Nationally, 15 to 20 panels conducted annually, each attended by over 200 Members, including KanCare Members ▪ Specific KanCare Member research panels conducted in 2021 and 2022 to gain insights on desired value-added benefits

Conducting Surveys to Understand Member Needs

We use our Voice of the Member Loop to identify and understand our biggest opportunities for improving Members' overall experience. We employ multiple surveys to ensure representation from our entire Member population. Results from these surveys are reviewed and analyzed, and we create our improvement action plans based on the results and comments.

Satisfaction with Support Staff

In 2022, **96.4%** of our Kansas HCBS CAHPS survey respondents rated their support staff as "excellent" — **10.3 percentage points higher** than our baseline score of 86.1% in 2019.

Conducting Surveys to Understand Member Needs	
Key Member Indicator (KMI) Survey	▪ Proprietary survey to gather feedback on Member experience ▪ Separate surveys conducted for adult, family and children (TANF or CHIP) Members and LTSS Members ▪ Administered telephonically through third-party vendor ▪ The final question is open-ended and asks what UnitedHealthcare can do better; these verbatims are reviewed monthly and used to improve Member experience ▪ Member services conducts follow-up calls to Members who shared a concern to verify their concern was resolved
The United Experience Survey (UES)	▪ After each call with member services, Members are given the chance to provide feedback through a short survey ▪ Members can rate their call experience from zero to 10 ▪ A supervisor conducts a follow-up call with all dissatisfied Members to verify concerns were resolved
HCBS Member Survey	▪ Assesses Member satisfaction with health plan and care coordinator ▪ Identifies all Providers the Member is working with to encourage dialog between the Member and their Providers to enhance coordination of care
Digital Voice of the Customer Feedback	▪ We gather feedback using Qualtrics monitoring to gather Member feedback and satisfaction with our Member portal ▪ Qualtrics allows us to identify themes in Member comments, the purpose of their portal use, what tasks they are completing and overall

Conducting Surveys to Understand Member Needs	
	satisfaction with their experience. For example, Members report an NPS of 80 when using our Live Chat feature, which is considered best in class for any business or organization
Annual CAHPS® Survey	▪ Required Member survey to assess Member satisfaction with PCPs and specialty care practitioners that indicates the quality, timeliness and appropriateness of provided care ▪ Results of the survey are used by the Quality Management Committee (QMC) to create action plans for improvement as part of the QAPI and submitted to Kansas Department of Health and Environment's (KDHE's) Division of Health Care Finance, NCQA and KDHE's external quality review organization (EQRO) annually
Substance Use Disorder (SUD) Survey	▪ Required annual anonymous survey to Members who accessed SUD treatment ▪ Designed using nationally recognized NCQA population health management standards using SDOH domains, assessing Member experience with substance use treatment Providers in Kansas ▪ Feedback and recommendations from EQRO and State used for future action

Our holistic and integrated approach to feedback helps us deliver person-centered and culturally appropriate care to make our operations, service delivery and Member materials even better. We employ multiple approaches to invite Members to join the MAC or to provide feedback through surveys. We also use our *Member Handbook*, our secure Member portal *(myuhc.com),* our public website (*uhccommunityplan.com/ks*), letters, phone calls, email and Facebook to invite Members, family members and representatives (caregivers) to take part in the MAC or otherwise provide us feedback. Our member services staff, service coordinators and community partners (including advocacy groups) can identify and assist Members, family members and caregivers who are interested in serving on the MAC or sharing input.

Understanding Members' Needs and Expectations Through Net Promoter Score

We use the Net Promoter Score (NPS) system across all our survey methods to help us understand Members' needs and expectations. The NPS system is a widely used market research metric that employs a single question to assess an individual's loyalty to a company. We employ the NPS likelihood-to-recommend question as part of all the other larger surveys we conduct to gather Member feedback. Survey examples include the home- and community-based services (HCBS) member survey, CAHPS survey, member services post-call surveys, key member indicators (KMIs) feedback through LTSS staff and feedback from member services identified in call calibration. Typical NPSs of top consumer brands include Apple's 61, Netflix's 67, Zoom's 72, Amazon's 73, USAA's 75 and Starbucks' 77. We ask the active Members we survey the NPS question, "How likely are you to recommend us to a friend or colleague?" **Our current 2023 Kansas NPS of 76 is considered best in class for *any* business or organization (health care or otherwise).**

Act and Evaluate: Review and Use KanCare Member and Family Feedback

To enable equitable person-centered care, we have a comprehensive approach to data collection, monitoring and analysis. Partnering with Members, we gather their feedback to tailor our supports and prioritize their satisfaction with the quality of care and service they receive. We collect and record information from direct interactions with Members, caregivers, Providers and

our outreach efforts in our integrated clinical platform, always remembering that this data represents their voice.

Member Advisory Committee Feedback Drives Improved Member Experience

The Member Advisory Committee (MAC) welcomes all Members and fosters fresh perspectives to stimulate innovation and improve programs for a better future. Attendees of the MAC have contributed valuable ideas, including enhancing the transportation benefit to allow rides to church or the grocery store. We prioritize the participation of all Members, particularly those with disabilities and in rural communities. Our MAC comprises about 65% LTSS waiver Members, ensuring feedback from vulnerable populations. We eliminate barriers to participation, offering accessible facilities, phone options and transportation solutions. We provide convenient meeting times and create a welcoming environment, both in person and virtually. We value our Members' thoughts on health equity, benefits, Providers, service delivery, community support and any other concerns, as these insights are vital to improving our support for them.

We Use Member Feedback for Personalized Engagement to Improve Satisfaction

To listen to our Members effectively, we engage with them individually. During their visits to our Member portal or mobile app, during or calls into member services, we ask for their communication preferences, including language, pronouns, format and the need for interpreter or translation services. By noting these preferences, we can tailor our outreach to maximize engagement and optimize their health outcomes. We review and analyze feedback from multiple sources to improve the Member experience and develop plans to address areas of concern.

We Use Feedback to Get New Ideas for Member Materials

Members provide us with new ideas for Member materials. One example is the Well Care Checklist we developed based on MAC meeting conversations about the best questions to ask a Provider during a visit. This feedback prompted us to create the checklist, which covers items Members can discuss with their doctors. The initial draft was developed and presented to the committee at the next meeting. Members provided positive feedback, indicating they felt the checklist would help them better prepare for their doctor visits. The checklist has since been incorporated into the *Member Handbook* and created as a standalone document.

Easy-to-Read Member Materials

"UnitedHealthcare makes it easy for me to understand my plan every time they send a pamphlet out and makes it easy for my wife and son to understand it."

Another example of a gap identified by a Member during a MAC meeting: understanding of the prescription benefit. Through feedback and additional input collected through Member verbatim comments from the KMI survey, we improved how we educate Members about pharmacy benefits. During the next MAC meetings, we shared a newly developed education piece titled "Is my medicine covered?" We improved our education on the benefit through the *Member Handbook*, the public web portal (*uhccommunityplan.com*) and our *HealthTalk* newsletter. Based on feedback from Member Research Panels and MAC meetings, we enhanced our UnitedHealthcare mobile app. We simplified the prescription process, adding more convenience for Members to view, manage and order home delivery prescriptions within the app. **Year-to-date, our digital engagement has increased 295%, logins to our mobile app are up 533% and Member satisfaction results are up almost 30%.**

We Use Feedback to Improve Services We Offer

Our surveys help identify areas where we are doing well and opportunities for improvement. We assess our survey results, including responses to open-ended questions, to improve the Member experience with our benefits or Providers. When an area of opportunity is identified, we solicit ideas and suggestions for improvement from our MAC. Changes to value-added benefits based on direct feedback include changing the Home Helper Catalog benefit to a $50 debit card and updates to our added adult dental benefit. In addition, in 2024, we are adding a $50 debit card reward specific to our rural and frontier Members in direct response to the feedback, "No one knows what it's like to be us out here."

We Use Feedback to Improve Our Customer Service

We use our companywide post-call survey (UES) as a valuable tool for evaluating Member experiences, assessing staff performance and identifying training opportunities. After a call, Members have the option to participate in the automated survey, where they can provide ratings and leave verbal comments. Our member services quality staff closely monitor and analyze survey results, looking for trends and areas for improvement. In cases of dissatisfaction, supervisors follow up to ensure resolution. Through focused call calibration sessions, advocate training and employee engagement, we have seen a notable improvement in **UES results, with satisfaction levels increasing from 90% in January 2023 to 93% in October 2023.**

We Use Feedback to Assess Our Quality of Care

The CAHPS® survey is another tool for insight into our Members' experience with their Providers and us. CAHPS survey results provide an indicator of the quality, timeliness and appropriateness of care provided to Members and create action plans for improvement. For example, we monitor a Member's access to primary and specialty care, tests and treatment to help us identify the Member's perceived barriers to access and availability. As a result, we have recently grown our Provider network by actively recruiting nine medical groups, representing more than 90 possible individual Providers with Kansas Medical Assistance Program enrollment. These efforts added 16 physicians — including one pulmonologist, two OB/GYNs and one cardiologist — to our rural and frontier network.

Improved CAHPS Ratings

Our most recent Kansas CAHPS results-related rating of the health plan Medicaid Child showed **improvements from 72% to 80%** from 2022 to 2023.

Our QMC plays a crucial role in evaluating the impact and effectiveness of our QAPI process. Each year, we conduct a comprehensive evaluation of our QAPI, informed by the prior year's Quality Program Evaluation. This evaluation is detailed through a set of documents, including the quality improvement program description and the quality improvement work plan, which establish goals and objectives for continuous quality improvement. By incorporating listening and Member survey results, we measure performance in various areas such as establishing benchmarks, monitoring performance, assessing overall satisfaction levels, evaluating service performance and monitoring access to care. This approach enables us to meet Member expectations and continuously improve the quality of our services.

Improve: How We Use Member Feedback to Improve the KanCare Program

We use the results from our listening tours, surveys and quality program to evaluate the Member experience and quality of care and services and to identify opportunities to improve care and services that we can affect directly. Member Advisory Committee meetings are open to all stakeholders, including our State partners, who regularly attend to hear feedback directly from Members. We shared with our State partners, and Kansas Legislatures at the Bob Bethell KanCare Oversight Meeting in Q4 2022, what we learned from listening to our Members.

COVID-19 Vaccination Success for the Latino Community

Through community engagement and feedback from our Members, we recognized that lower COVID-19 vaccination rates among Latinos were primarily due to lack of access rather than vaccine hesitancy. To address this issue, we collaborated with the Kansas Latino Stakeholders coalition and implemented solutions, including bilingual walk-in clinics, simplified sign-in processes and educational campaigns to alleviate concerns about immigration status. In addition, UnitedHealthcare sponsored equity-focused vaccination events and provided support in the form of technical advice, translations, volunteer hours and Member communication campaigns. Per KDHE, **our involvement frequently resulted in a tenfold increase in turnout to these events that resulted in higher vaccination rates for people in Hispanic and Latino communities** than for non-Hispanics and non-Latinos. We also shared our learnings and successful strategies with other groups across the state.

Identifying and Filling Other Care Gaps

Our QMC consolidates all feedback and data points from all listening interactions and all the surveys to develop improvement action plans. Based on both survey scores and verbatim comments from the various surveys, we identify key priority areas for constant improvement:

- **Access to care:** Verify adequacy and availability, enhancing *Provider Directory* tools and resources, assisting Members with appointment setting, expanding telemedicine and ancillary access (e.g., behavioral health, dental, vision)
- **Plan features:** Enhance and simplify new Member materials, welcome call scripts and continual advocate education
- **Ease of use:** Simplify pharmacy experience, enhance online tools and service model
- **Personal interactions:** Refine member services and enhance assistance with appointment setting, transportation and pharmacy benefits

Advocating for KanCare Program Enhancements

We actively apply Member feedback to improve the KanCare program, collaborating with the State, community partners and other MCOs. By sharing what we learn, we contribute ideas to enhance the lives of Kansans and improve KanCare as a whole. The addition of adult dental benefits to the program is a prime example of this collaborative effort — adult dental has been a recurring topic in MAC discussions and has been repeatedly requested by Members in their verbatim comments. Active engagement with our State partner, as well as collaboration with the Ombudsman's office, Providers, community partners and other MCOs, played a key role in KanCare expanding dental benefits for adults to include restorative treatments — a significant achievement for the program and a testament to the collective effort of all stakeholders involved.

We value and prioritize the feedback of KanCare Members and their families as a cornerstone of our commitment to continuous improvement. It is through this feedback that we drive ongoing enhancements to our programs and services, which is reflected in being the top-rated plan overall in NCQA's 2023 Health Plan ratings.

Member Experience

6. Describe the bidder's approaches related to the following with respect to the bidder's Provider directory for KanCare:

Our *Provider Directory* Approach

The goal of our approach to the *Provider Directory* is to make **timely, accessible** and **accurate** information available to Providers and Members to support informed choices and exceptional care. We deliver on this promise by (1) using technology to make it easy for Providers to update data, (2) regularly monitoring the accuracy of the data and updating where necessary and (3) providing a Member-centric, accessible, usable electronic version. Our *Provider Directory* is:

- **Provider centric,** as it reduces Provider burden by enhancing administrative processes, streamlining our data management approach and offering a centralized repository of Provider data
- **Accessible to all Members,** available in multiple languages (as shown to the right) and formats for Members with visual impairments
- **Highly usable,** [redacted]
- **Accurate and enhanced** through our Provider Verification Office, roster managers and Trust Evaluator artificial intelligence (AI) tool
- **Comprehensive,** offering information that includes Providers' specific linguistic or cultural qualifications and necessary accommodations

Figure 6-1. Our *Provider Directory* Language Options

Our *Provider Directory* exceeds the requirements outlined in the RFP, providing comprehensive Provider information. We verify the accuracy of this data regularly. To enhance accessibility, the directory is available in multiple languages and formats for all Members, including those with limited English proficiency or visual impairments. Our member service advocates actively work with Members to address any challenges in using the directory. Our websites offer convenient features like [redacted] and distance-based search, improving the overall Member experience. These capabilities align with **Scope of Services 7.10.8** and support the State's goal of reducing administrative burden for Providers (1.1.E.1). In addition, we aim to improve Member satisfaction, advance the State's goal of enhancing Member experience (1.1.A.1) and empower Members to define their health and wellness goals. By leveraging our core capabilities of continuous improvement and focusing on Member health outcomes, we advance the usability and effectiveness of our directories in Kansas.

Meeting Members' Cultural and Disability Needs

Our *Provider Directory* complies with Section 508 of the U.S. Rehabilitation Act and includes Provider languages spoken and facility wheelchair accessibility.

a. The elements of information included, beyond those specified in the RFP, for each participating Provider.

Elements of Information Included in Our *Provider Directory*

Our *Provider Directory* features all information required by the State, plus key information our experience has shown increases Member satisfaction. For example, some Members may feel more comfortable discussing their health goals with a Provider who has an identified area of expertise with LGBTQ+ health care needs, which is included as an expanded element within our *Provider Directory*. The table that follows outlines both the required elements of the *Provider Directory* and the expanded elements that are included for Member benefit.

Our *Provider Directory* Information	
Required Elements	**Expanded Elements**
▪ Complete name ▪ Address for all office locations ▪ Phone number, including teletypewriter ▪ Accepting new patients ▪ Provider type/specialty/services provided ▪ Ages served ▪ Group affiliations ▪ Hours of operation and after-hours ▪ Website ▪ Cultural and linguistic ▪ Accommodations (physical accessibility) ▪ Link to map	▪ Customer rating ▪ Insurance plans accepted (not included outside Medicaid inclusion) ▪ Licensure ▪ Service area for HCBS Providers ▪ Self-attestation to LGBTQ+ and area of expertise (i.e., behavioral health Providers) ▪ Public transit availability ▪ Special needs accommodations available ▪ Telehealth services

b. The bidder's approach to developing, maintaining, validating and monitoring the accuracy of the information in its Provider directory.

Approach to Development, Maintenance, Validation and Monitoring

Developing and maintaining an accurate *Provider Directory* requires ongoing commitment and continuous attention. Each Provider interaction is an opportunity to collect and update Provider information — from their initial application to ongoing communications and outreach. We continually verify the accuracy of our Provider data. For example, in September 2023, we executed **1,183 secret shopper calls, of which over 88% of Provider data was validated accurate.** We review and update Provider information daily, capturing crucial details such as cultural competency trainings, languages spoken, facility accommodations, equipment availability and panel status, including whether Providers are accepting new patients, from various sources like office visits, Onboard Pro, Practice Assist or My Practice Profile.

We gather data for our *Provider Directory* through daily interactions with Providers across all lines of business, including Medicaid, Medicare, employer sponsored and others. By incorporating these updates into our directory, we help Members find Providers who best meet their unique needs and preferences. Our *Provider Directory* is regularly updated using the bidirectional PRN Provider network (PRN) file, which contains the Provider data displayed in our directory. When we identify necessary changes to a Provider's data, we update the PRN file to inform the State of the change. In addition, we actively reach out to Providers to improve data accuracy through feedback from Members, innovative tools and processes. Our provider advocates educate Providers on the importance of updating their information with the State,

providing guidance on using the KMAP Provider portal, delivering easy-to-understand demonstrations and how to obtain support through the KMAP Provider enrollment toll-free number and email address. Providers can conveniently update their information using the portal, and our provider advocates are available to assist them in their office locations. Once Providers update their information, it is sent to us through the PRN file **and reflected in our *Provider Directory* within two business days.**

Accuracy is a key component of an effective *Provider Directory*. In addition to monitoring return mail and fax logs, we update our online *Provider Directory* daily and no later than two business days after receiving updated Provider information per **Scope of Services 7.10.8F**. Examples of methods used to confirm *Provider Directory* accuracy include:

- **Provider Verification Office (PVO):** Our PVO team contacts network Providers regularly to update information, (e.g., analytics pointing to potential discrepant data, regulatory requirements, referrals from call centers). The PVO team performs outreach to confirm all required *Provider Directory* data elements such as name, location, office hours, telephone numbers, non-English languages spoken by Provider or office staff and whether the Provider is accepting new patients. If updates are required, we provide information for how to update their data with the State and/or include it in our daily PRN file.
- **Roster Managers:** In Q3 2023, we launched a new initiative to improve Provider data accuracy focusing on managing a facility's roster of participating Providers. A dedicated team of roster managers engages one on one, on-site with Providers to update their roster and review their facilities for accuracy. While on-site, we work with the Provider to submit any required changes through the KMAP portal. **Since launch, we have completed over 6,200 roster updates, a 35% reduction in Provider calls, a 24% increase in first-call issue resolution** and **improved our Provider experience rating by 29%.**

[redacted]

c. The features of the bidder's online, electronic Provider directory that promote Member usability.

Features of Our *Provider Directory* That Promote Usability

We offer a comprehensive online *Provider Directory* search engine that can be accessed through multiple platforms, including our public website (*uhccommunityplan.com*), secure Member portal (*myuhc.com*) and secure Provider portal (*UHCprovider.com*). To promote usability, our online *Provider Directory* offers a comprehensive online search engine to help Members easily find information about their health care Providers and facilities, which reduces burden for both Members and Providers.

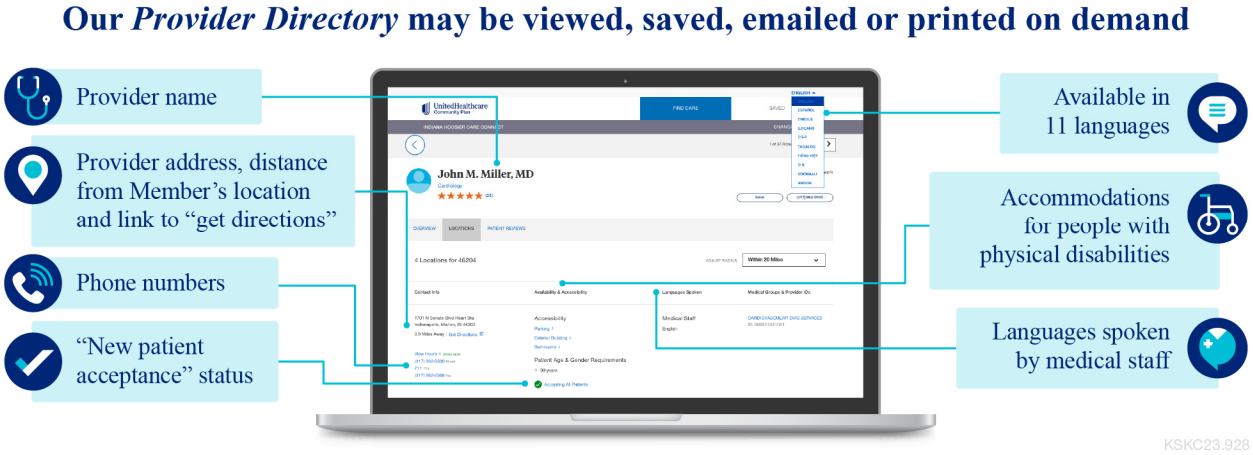
Aligning with the State's goal of reducing health care disparities, we work to achieve equity by increasing our *Provider Directory's* usability. KanCare Members can search based on location, specialists, cultural trainings and many other factors affecting a Provider's care delivery for Members. Further, our *Provider Directory* is accessible through our public website and within our Member portal. The directory is mobile enabled and provides Member support through chat (English and Spanish). Member service advocates and care coordinators can use our interpreter services with more than 240 supported languages for all other languages to expand access for Members.

Our Tailored *Provider Directory*

In 2022, **85%** of our Kansas Members were happy with the language assistance they received, and **82%** said it was easy to find a doctor who respects their beliefs, affirming our commitment to building a *Provider Directory* tailored to their needs.

We create a proactive, reliable, and simple experience for Members to find care that meets their personal preferences. Members and caregivers can view, download and print a copy of our *Provider Directory* from our website. Care coordinators assist verbally or send printed copies in the Member's preferred language or format for those Members and caregivers without internet access. Alternate formats available include large print, braille and audio.

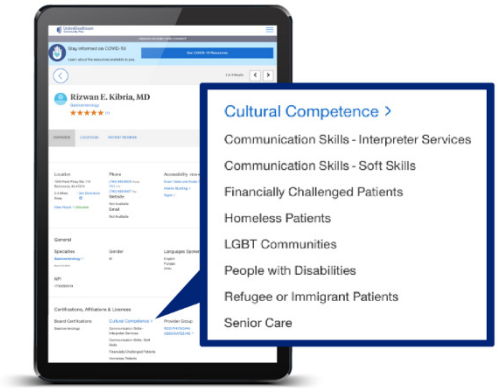
Figure 6-2. Our *Provider Directory* Capabilities



Helping Members Find the Right Provider

We have created a reliable and simple experience for Members to find care that meets their personal preferences. Our online resources are designed to meet the individualized needs and concerns of Members, with features that include 11 language offerings, appropriate reading levels (at or below a sixth grade reading level) and enhanced website accessibility for Members with visual impairments, dyslexia, color blindness and limited mobility when accessing keyboards. For Members requiring access to Providers with specific cultural, ethnic or social attributes, we collect targeted data and display each Provider's expertise, experience, training and certifications. For example, a Member can use our Find Care application on our website to filter and find an OB/GYN with expertise working with individuals with vision impairments.

Figure 6-3. Members Can Search for a Provider Based on Their Needs



[redacted]

Patient Experience Performance

UnitedHealthcare is the top-rated KanCare MCO in Getting Care (easily and quickly) with a subcomposite score of 4.5 out of 5 **and top-rated MCO overall with 4 out of 5 Stars in NCQA's Medicaid Health Plan Ratings 2023.**

d. The bidder's strategies to reduce Provider burden associated with providing information to create and maintain an up-to-date Provider directory.

Strategies to Reduce Provider Burden Associated with the *Provider Directory*

We have automated tools and streamlined processes to simplify Provider participation in the directory's creation and maintenance. Our initiatives aim to alleviate the burden on Providers:

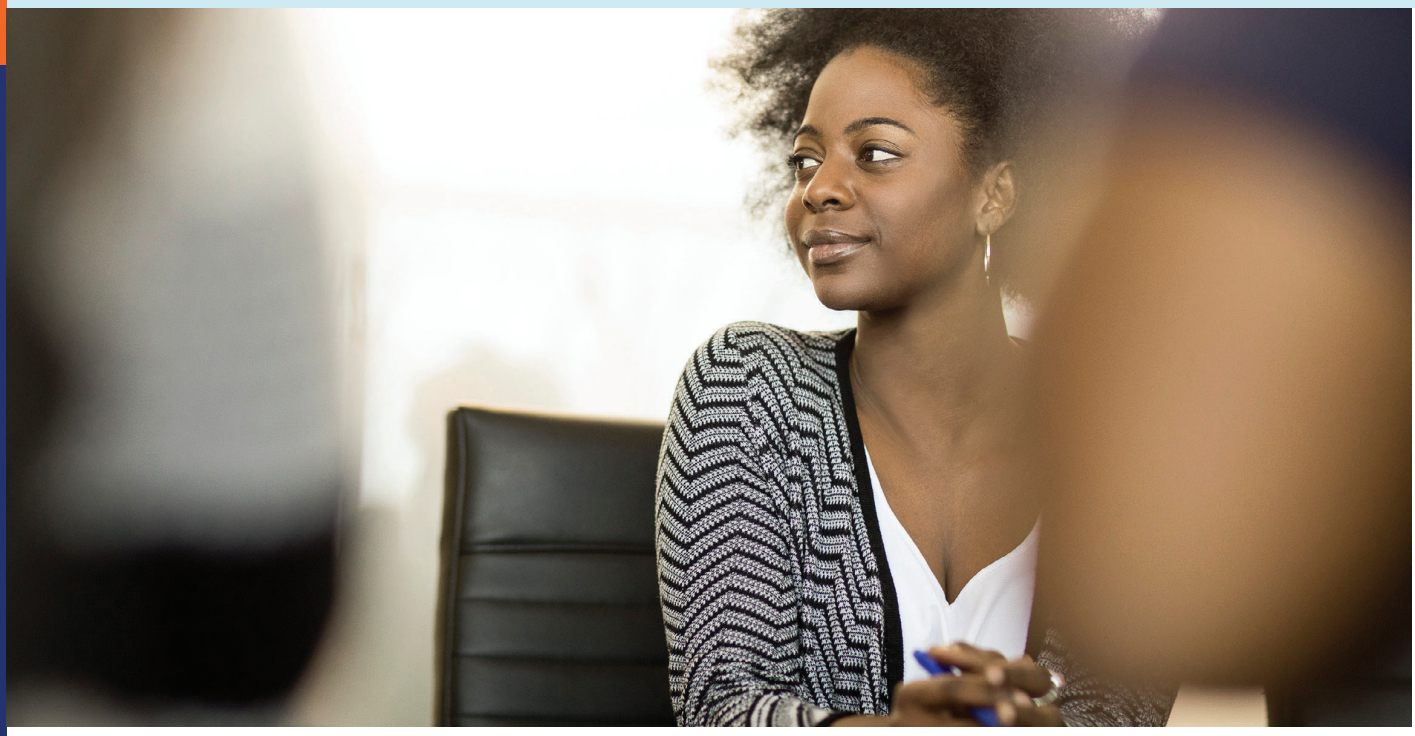
Tribal Health Provider

"UnitedHealthcare is at the top of the list because of your portal. It is wonderful, user friendly, super easy. We're so happy with you, I wish all our patients had your insurance."

- **Onboard Pro:** With input from network Providers, Onboard Pro is user-friendly and efficient, gathering all necessary *Provider Directory* data (e.g., credentialing) in one place, making it easy for Providers to see the status of their onboarding.
- **Online Directory Reporting Link:** Members can report invalid Provider information in the search results. We then contact the Provider to proactively verify and update their data.
- **Provider Portal:** *UHCprovider.com* conveniently provides direct links to the KMAP portal (strongly encouraged for Providers to use), for easy Provider updates and necessary changes. They can also submit updates or changes through our Provider portal, which are included in the daily PRN file distributed to the State.
- **Integration with the Council for Affordable Quality Healthcare (CAQH) ProView®:** Onboard Pro seamlessly integrates with this national clearinghouse, eliminating redundant work for Providers. By using auto-populated information from a Provider's account, we minimize the data that needs to be provided, saving valuable time and effort.
- **Provider Chat:** Through *UHCprovider.com*, Providers have access to our omnichannel feature, Provider Chat. This tool starts with an introductory message to determine the type of support needed, allowing the session to be directed to the best-suited live agent. If necessary, Providers can transition to a phone call with the same representative for further assistance.

These strategies enable us to seamlessly update the State on changes or updates via the daily PRN file, and together, help ease Provider administrative burden and enhance Member care.

Integrated, Whole-Person Care (Tab 7c)



Building Pathways to Education and Career Advancement

Employment and income impact health. That is why we offer eligible Members up to $200 toward continuing education. We partnered with a local organization to design a custom program for Members to use their continuing education benefit to learn the fundamentals of medical coding. Over 70 Members have enrolled and are on the path to an entry-level career in health care.

Kansans United

United Healthcare Community Plan

Integrated, Whole-Person Care

7. Describe the bidder's proposed MCO staffed Care Coordination model for KanCare and include the following in the bidder's response:

UnitedHealthcare's Care Coordination Model

Care coordination is at the heart of **our mission to advance compassionate, trauma-informed, equitable whole-person care**. In the following pages, we outline the approach, experiences and capabilities our care coordination model brings to the State of Kansas' (the State's) KanCare Medicaid and CHIP Capitated Managed Care Services (KanCare) program. Our care coordination model includes:

Strong DM Program Outcomes

For Members engaged in our high-risk pregnancy program, **timeliness of prenatal care is 56% compared to a control group (Members who are eligible but who did not opt to enroll) of 44%.** For our rising-risk maternal health program, there is a 1.4% more favorable neonatal abstinence syndrome rate for enrolled versus non-enrolled Members.

- **Distinguishing our care coordination approach by offering each Member a person-centered interdisciplinary team (IDT)** that includes the care coordinator, Community Health Workers (CHWs), Providers, the Member, caregivers, designated representatives, specialty Providers, behavioral health (BH) experts, our pharmacist, home- and community-based services (HCBS) Providers, the community care coordinator and others based on the Member's needs, preferences and applicability. The IDT works collaboratively, forming a circle of support around each Member. Using Member-informed, person-centered service planning, each Member is empowered and at the center of their IDT, driving whole-person longitudinal care.
- **Embedding Kansas-based care coordination and CHW staff in communities across the State.** We are Kansans serving Kansans — that is what we do. Through active listening and our deep community connections, we continue to put Members — our neighbors — at the center of our model. Our care coordination team has served KanCare Members for over 10 years and has deep knowledge of local health care systems, community resources and Providers to better connect Members to the services needed to help them thrive.

- **Establishing clearly defined roles, responsibilities and functions for delegated models and those with shared responsibility.** Our approach includes Community Care Coordination, targeted case management (TCM), HCBS waiver services management and community BH services, including through Community Mental Health Centers (CMHCs) and Certified Community Behavioral Health Clinics (CCBHCs). Clinical data exchange and role-based access to our care coordination system, CommunityCare, empowers both internal and external care teams to address Members' needs.
- **Using updated data insights** from sources such as our social determinants of health (SDOH) dashboard, our Hotspotting tool that alerts care teams to gaps in Member care and Impact Pro® algorithm-based alerts that inform our daily outreach, including Member, Provider and caregiver engagement. **In 2021, UnitedHealthcare screened over 4 million Members for SDOH risks/needs nationwide, referring three out of four Members to community resources for SDOH-related needs when desired.**

- Connecting Members to our **broad array of specialized chronic condition and disease management (DM) programs**, such as our cancer DM program and high-risk pregnancy program through screening and assessments.
- Monitoring care coordination through industry-recognized continuous quality improvement (CQI) initiatives to improve individual and population-wide outcomes. **KanCare Members engaged in our care coordination demonstrated improved HEDIS® outcomes from 2021 through 2022 as follows:** Colorectal cancer screenings increased from 43.8% to 48.7%, breast cancer screenings increased from 45.8% to 50.6% and the percentage of Members with blood pressure readings less than 140/90 increased from 24.9% to 43.4%. Pharmacotherapy management of COPD during the same period using systemic corticosteroids increased from 61.2% to 65.7%. Members engaged in our Nursing Facility High Risk Diversion program have less than a 2% admission rate compared to the 5% admission rate for those transitioning into a nursing facility in the Frail Elderly (FE) and Physical Disability populations.
- **Evolving our clinical processes** based on the State's needs. In accordance with **Scope of Services 7.4.6,** we will incorporate the new community care coordinators we recruit into the Member's person-centered service plan (PCSP) and IDT as applicable. We will subcontract with local entities (Community Care Coordination Providers) to perform community-based care coordination and meet all related contract requirements.

a. The bidder's proposed care coordinator staff distribution and location.

Existing and Proposed Care Coordinator Staff Distribution and Location

We hire local staff, with more than 300 KanCare dedicated employees strategically located across the 105 counties we serve, including rural and frontier counties. Our staff understands the communities where they live and work and are invested in caring for neighbors. Our care coordinators are specialized (e.g., we have HCBS waiver care coordinators, foster care coordinators, maternity/NICU care coordinators and complex case management coordinators). Team members have the training needed to work cross-functionally, including support of BH needs. Our care coordination model includes CHWs, who function as care coordination extenders, allowing care coordinators to work at the top of their licensure by supporting administrative, outreach and face-to-face activities as an integral part of the IDT.

We locate and distribute staff based on Member population density and on population health risk, both of which are identified via Impact Pro® and similar tools. Through a monthly review process, our leadership monitors location of staff compared to enrolled Members and adjust staffing accordingly. For example, we may adjust caseloads to accommodate for distance of care coordinators to Members and hire additional staff to limit the distance between care coordinator and Member to less than 60 miles. All our staff are equipped with cellular-enabled laptops and

other tools needed to travel to Member locations, including rural and frontier locations. Our team recruits staff to work in rural and frontier locations by offering a supportive work experience and competitive compensation, including sign-on bonuses and internal staff referral bonuses. Staff is also distributed based on contract requirements and the State's expressed needs. For example, we are adding staff to support the additional in-person and telephonic touchpoint requirements described in **Scope of Services 7.4.5. We will add 19 new long-term services and supports (LTSS) care coordinators in 2024 to support this contract change.**

Helping a Member with SDOH Needs in a Rural Area

Paula lives in an area with limited resources in rural Kansas. She recently moved to a rental home that did not have a refrigerator, and unfortunately Paula could not afford to purchase one. She desperately needed refrigeration to store lifesaving medications and food. Our CHW worked with Paula to locate a community organization that would donate a refrigerator. The organization was three hours away from Paula's home, and lack of transportation made their donation unviable. The CHW used Google and Facebook to search for a closer unit and found a local vendor with refrigerators at reduced prices that would deliver to Paula. **The CHW requested internal SDOH funds to purchase the refrigerator since Paula needed to refrigerate her medications as soon as possible.** We approved these funds quickly. Paula got the refrigerator and was able to continue with medication management to maintain wellness.

b. The bidder's approach to avoiding duplication of Care Coordination with delegated or other models of Care Coordination (e.g., Community Care Coordination, targeted case management [TCM], Certified Community Behavioral Health Clinic [CCBHC], OneCare Kansas).

Avoiding Duplication of Care Coordination

As KanCare partners for the past 10 years, we have the processes in place and the Kansas-based knowledge and experience to avoid care coordination duplication with delegated and other models of care coordination, including community care coordinators, TCM, CCBHCs and OneCare Kansas. For example, the TCM is the Member's primary point of contact for IDD waiver services, and we partner with TCMs today to support this model and provide coordinated services. We successfully avoid duplication of care coordination with delegated and other models of care using the following strategies:

- **Establishing single points of contact with delegated and Community Care Coordination entities, including with TCMs and CCBHCs to promote a clear path for Member support.** We conduct joint visits with TCMs and CCBHCs completing our required assessments in the same person-centered planning meeting to foster collaboration around care planning and clarify scope of responsibility between our care coordinator and the TCM or CCBHC staff. Case conferences are an important and effective element of our care model. Conferences confirm treatment and services are integrated and aligned

"I'm a Medicaid TCM and Shannon makes it easy to work together so that we both are able to assist Members/families with whatever needs arise within each of our own specialties. Shannon is so knowledgeable in the field, which is often difficult to achieve since our field can be so broad. She is able to be a valuable resource to me but more importantly, to the individuals and families that she has on her caseload. Shannon has proven time and again that she excels in her position as care coordinator. **I enjoy working with her immensely and I believe that Members feel the same."**

– Colleen Hunter, Senior TCM

A Step Above, LLC

in a way that best supports the Member's goals while avoiding duplication. We partner with CCBHCs to jointly provide BH services for Members with high-risk BH conditions. Daily collaboration and communication with CCBHCs mitigates service duplication and helps the Member access joint supports. We understand when a community care coordinator is unavailable, we are responsible for all care coordination functions.

- **Sharing information across the care team.** CommunityCare, our clinical management system, provides a holistic, centralized view of our Members' information, including utilization of authorized services, pharmacy, health screenings and risk assessments, care plans and DM programs. The tool is used by clinical (including physical, BH and pharmacy), quality, utilization management (UM), member services and other internal teams, as well as by external Providers (depending on preference) to facilitate coordination and share information. Collaboration via CommunityCare improves coordination and reduces potential duplication of services. OneCare Providers have access to Member care plans in CommunityCare.

Our existing partnership with external Providers on all aspects of care coordination supports our ability to streamline care. As one of our external Provider partners notes, our staff "excels" at doing this work.

c. The roles, responsibilities, and functions for staff performing Care Coordination responsibilities.

Care Coordination Staff Roles, Responsibilities and Functions

Our care coordinators have the understanding, licensures, local knowledge and specialties needed to listen to and advocate for KanCare Members. We promote a collaborative approach to care coordination and include external care coordinators in joint care planning. We briefly describe our key care coordinators' roles, responsibilities and functions in the following table. All care coordinator roles align with **Scope of Services 7.4.7 (B, C) and Appendix L.** A Member's single point of contact may either be our care coordinator or a community care coordinator such as a TCM.

Care Coordinator Title/Role	Brief Description of Responsibilities	Key Function(s)
Care Coordinator ▪ BH ▪ LTSS ▪ RN ▪ Foster Care ▪ Maternity ▪ Disease Management	▪ Partners with Member to promote health screens, assessment completion, plan of service and PCSP completion ▪ Coordinates IDT to address Member's physical health, BH, SDOH and related needs ▪ Leads Member outreach, follow-ups, care transitions, in-person visits ▪ Leads care planning, addresses care barriers, promotes equitable care	▪ Assists Members with defining and meeting their personal health goals through our integrated, whole-person care approach ▪ Specialty care coordinators have varied functions. For example, maternity case managers support/educate Members to improve birth outcomes through our Healthy First Steps program or high-risk maternity program. Foster care coordinators streamline Member care experiences across child welfare

Care Coordinator Title/Role	Brief Description of Responsibilities	Key Function(s)
	▪ Serves as Provider and external care coordinator point of contact	stakeholders and advocate for integrated care planning
Community Health Worker	▪ Performs key care coordination administrative functions allowing care coordinators to operate at the top of their licensure	▪ Outreaches to Members to engage in care coordination; in-person visits, Provider and community-based organization (CBO) visits; advocates for Members' needs across the care delivery system
SDOH Support Staff	▪ Develops relationships with housing authorities and CBOs to address housing, transportation, food access and employment barriers	▪ Collaborates with and supports care coordination teams to address Members' SDOH needs and barriers to care

Recognizing the new role of the community care coordinator, we are already preparing for these Providers to have distinct roles and responsibilities. We will partner with community care coordinators as active participants in the IDT. We are already deploying this collaboration with our longtime partner, Overland Park-based communityworks, inc. Before KanCare, communityworks was incorporated as a home health agency in 1991 and recognized as a premier agency for assessment, plan of care development and Money Follows the Person for Kansans on the brain injury waiver, physical disability waiver, Frail Elderly waiver and associated waiting lists. Communityworks' owner, Dr. Janet Williams, has a long history of providing excellent case management and person-centered services to Kansans with disabilities. We have a strong partnership with Dr. Williams and similar Providers and will build on these relationships to develop an effective and collaborative community care coordinator model.

d. The bidder's approach and strategies to effectively engaging Members, particularly those who may be more challenging to engage, to participate in Care Coordination.

Approaches and Strategies for Engaging Members in Care Coordination

We begin our engagement process through effective risk stratification and ongoing screening for SDOH needs for 100% of KanCare Members. Risk stratification identifies which Members need care coordination and segments risk levels so we can support Members with the right programs at the right time through the right care coordinator. It also helps care coordinators detect Member needs changes, including the potential benefits of a higher level of care or opportunities to reduce care coordination intensity. Our risk stratification and segmentation process assigns every Member to one of three risk levels. To engage Members in care coordination, we use the following approaches, to name a few:

Motivational interviewing, strengths-based case management and active listening: Care coordinators and CHWs are trained in applying all three techniques and additional approaches to promote Member care coordination engagement. Motivational interviewing, for example, is a consultation method that helps Members who are undecided about or hesitant to change their behaviors by actively listening to the Member's expressed concerns, challenges and goals.

Motivational interviewing incorporates a readiness to change approach to help Members explore feelings and motivations, uncovering personal goals and desires that can encourage increased engagement. Motivational interviewing helps our team identify barriers to care, which we then assist Members to help address. These include transportation, food, housing access and parental supports.

Figure 7-1. Local Community Presence Increases Engagement

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Community presence throughout Kansas helps promote UnitedHealthcare and increase program engagement: UnitedHealthcare's plan leaders, care coordinators, CHWs and staff prioritize time to collaborate with community stakeholders to present at and attend community events, screenings, partner fairs and school and children's events. Our ongoing community presence helps reduce Member hesitancy to engage in our program and increases program recognition. For example, our ambassador, Dr. Health E. Hound® recently attended a March of Dimes community event.

Incentives motivate Members to join programs: We offer an array of incentives to encourage ongoing care coordination (and DM program) engagement. Members can earn debit card rewards for completing their annual health screening and well-child visits. Reward amounts range from $10 to $75 annually. We mail a gift card or add funds to an existing card when a Member completes an activity.

Behavioral health care coordination supports LTSS Members' ability to self-direct care and make informed choices: Members who access LTSS and live with BH and substance use disorder (SUD) conditions sometimes find it difficult to remain engaged in their benefits and services due to condition symptoms and/or other barriers to care. We have specialized BH care coordinators (and CHWs) who have the expertise needed to effectively support these Members so they are empowered to direct their own care.

Care coordinator co-location increases engagement: New for the next iteration of KanCare, we are proposing four full-time foster care coordinators to be co-located (if agreeable and permitted) at the State's four foster care agencies to promote integrated care and increase engagement among Members navigating foster care. As of November 2023, we initiated dialogue with St. Francis Ministries, Cornerstones of Care, KVC and TFI Family Services to explore this offering. These entities are considered our Members' legal guardian. We know that due to large caseloads and Member needs, there are benefits entities can experience by having easy on-site access to our care coordination team.

Over 95% Member Satisfaction

According to our HCBS and annual Member survey results, **95.35% of Members are satisfied with our LTSS care coordinator.**

"Never give up" approach to reaching Members where they are: It is not uncommon for Members to find it challenging to engage in their benefits especially when barriers to care such as language, cultural and ancestral beliefs about health care, SDOH needs (ranging from lack of transportation to food access to housing access to safety to geographic barriers to physical ability barriers and more) may cause hesitancy to obtain routine and specialty care. We are leaders at

supporting Members who are not engaged in care and are creative in our outreach strategies. Our care coordinators and CHWs make individual in-person visits to Members' locations (including for Members who are in school or who are experiencing housing instability). We contact the Member's PCP or other Providers and request their support. Our team leverages all options to locate Members' updated contact information, including reviewing 834 files, Provider and pharmacy claims and Kansas' health information exchange data. We work with CBOs to contact Members. We engage the Member's pharmacy to deliver a message to the Member on our behalf. We simply do not give up on engaging Kansans in our program.

e. The bidder's proposed Care Coordination caseload ratios, process for establishing ratios, and the approach for monitoring to ensure ratios are adequate to meet Care Coordination requirements.

UnitedHealthcare's Proposed Care Coordination Caseload Ratios

We have staffing ratio guidelines for functional areas developed over many years across many populations. These guidelines consistently align with KanCare contract requirements and drive program success. We consider Members' nuanced needs and SDOH variables to align clinical staff to Members. The following table lists care coordinator staff ratios by specialty. Ratios can be adjusted based on membership and program requirement changes.

KanCare Population Served	Care Coordinator Caseload Ratio
IDD, Physical Disability and Frail Elderly (FE) HCBS Waiver	1:60
Serious Emotional Disturbance HCBS Waiver	1:75
Autism Waiver	1:75
Brain Injury and Technology Assisted HCBS Waivers	1:40
HCBS Wait List	1:60
Institutional Settings	1:200
Foster Care	1:40
High-Risk Maternal and NICU	1:40
Low-Risk Maternal and NICU	1:75
Other Identified Level 1	1:180
Other Identified Level 2	1:60
Other Identified Level 3	1:40

Process for Establishing Care Coordination Ratios

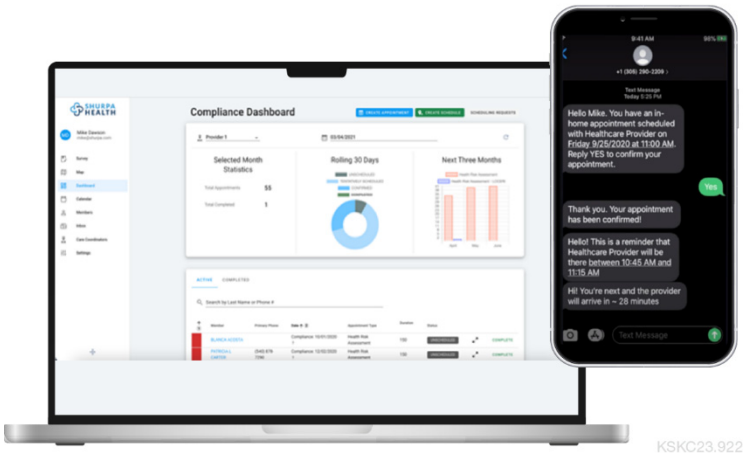
Our process for establishing care coordination ratio requirements aligns with **Scope of Services 7.4.8.** We develop care coordination ratios based on many factors, including Member acuity, geographic proximity between Members and staff and with the goal of making sure the IDT includes support staff (such as CHWs) in the Member's area to extend the role of the care coordinator. We leverage best practices from our support for Members based on our 10 years serving Kansans and experiences supporting 12 LTSS programs nationally to achieve optimal care coordination ratios, including complexity of need, geography and available community supports. Through our Workforce Management Project Model, we build upon this baseline to

account for changes in population risk distribution, enrollment, Members' evolving geographical location, and staff availability/capacity changes such as paid time off, family and medical leave and staff attrition.

Approach to Monitoring Adequacy of Care Coordination Ratios

Our leadership, managers and care coordinators deploy a variety of tools and processes to monitor care coordination ratio adequacy. We use the Shurpa platform, a blended workforce management and Member scheduling tool with flexible workforce monitoring dashboards, to track daily care coordination adequacy and forecast staffing. Shurpa can send automatic appointment reminders and updates by text message to Members throughout their day leading to increased Member engagement. Managers have higher visibility into care coordinators' caseloads using this tool, so they can arrange staffing as needed. Figure **7-2** depicts a sample Shurpa workforce management dashboard and a sample Member appointment reminder text.

Figure 7-2. Sample Shurpa Dashboard and Member Reminder



CommunityCare, our care management platform, provides caseload reports that managers check daily to verify that care coordinators' caseloads stay within expected ratios. Daily care coordination huddles where care coordinators communicate about needing help either with a case or their caseload allow managers to proactively address daily staff well-being and foster team-based clinical solutioning. Our workforce management director and health services director review our Clinical Staffing Model Report quarterly. This identifies the number of required care coordinators needed for each population based on membership volume, location and defined ratio. Based on this review, they evaluate and respond to circumstances that trigger an adjustment to caseload sizes, including care team outcomes, membership growth, geographic changes, Member changes in acuity or program changes.

f. Case assignment considerations and how the bidder monitors and manages vacancies to ensure Members' continuity of care.

Case Assignment Considerations

Our goal is to make care coordination as accessible and seamless as possible. When assigning cases, we consider an array of factors, including the population being served, Members' choices and needs, caseload ratios, acuity status mix, care coordinator qualifications, available support staff and the programs a Member is engaged in. We assign special populations required to receive specially trained care coordination to care coordinators who have the background and experience to serve that specialty. For example, Members with BH needs are assigned to BH care coordinators who meet contract requirements for experience and training to provide BH care coordination. When possible, we assign Members to a care coordinator **who lives and works in the same community as the Member** to allow for easier in-person visits and because the care coordinator has localized knowledge of available area resources.

Approach to Managing Care Coordinator Continuity and Vacancies

Our care coordination managers actively monitor their teams' caseloads with oversight from the health services director. When a care coordinator or CHW is unavailable for more than a few days, we assign a colleague with capacity to assume the staff's caseload until their return. In some cases, the caseload may be spread across several care coordinators. We promote care continuity across our team using shared care coordination platform, CommunityCare. All clinical, CHW and Member-facing staff have access to this system. Shared access allows care coordinators who are filling in for other staff to access each Member's case history, PCSP, IDT notes, assessments, contact details and SDOH gaps.

If a Member has changes or vacancies in their IDT, we notify the Member and collaborate with them to assign a new care coordinator. When advance notice of the departure is known, the Member will be notified at least seven calendar days prior and be given an alternate contact name and phone number. Once a new care coordinator is assigned, we contact the Member within three business days. Whenever possible, we use a warm handoff approach (by phone or in person) to introduce Members to their new care coordinator. The Member's PCSP and all authorized services remain in place. We review these at the next scheduled touchpoint. If we do not have notice of a staff vacancy, we assign a new care coordinator within three days. By using our capabilities to serve Members seamlessly, we increase Member trust in and engagement with our program.

g. How the bidder's Care Coordination program will identify and support the needs of Members who are not on a 1915(c) HCBS Waiver and have a temporary or transitional need for Care Coordination.

Identifying Members with Temporary or Transitional Care Coordination Needs

We identify Members who are not in a 1915(c) HCBS waiver and have a temporary or transitional need for care coordination through our innovative tool Impact Pro®. Using a variety of data, including medical claims, real-time admission, discharge and transfer alerts (ADT) and assessment data, we identify high-risk Members with care coordination needs. In addition, we identify Members through case rounds and direct CBO, Provider and agency referrals. Care teams receive automated referrals for Members admitted to a medical inpatient facility who are determined to be at high risk for readmission and for Members who are admitted to a psychiatric inpatient facility prompting engagement to identify needs.

Supporting Members with Temporary or Transitional Care Coordination Needs

Temporary and transitional care coordination is critical to helping Members (and families or caregivers) with special health care needs receive appropriate, self-directed continual care. Our priorities when coordinating care include the following:

- **Connecting Members directly to their assigned care coordinator and IDT** to proactively plan for transitional or temporary integrated needs (BH, SDOH).
- **Assigning a care coordinator to every network nursing facility (NF).** Care coordinators meet with the Member in person at least annually to determine whether the Member wishes to transition to the community. If the Member chooses community living, we assist with

transitioning them safely. **We have successfully transitioned 547 Members from an NF to HCBS since 2019. By year's end 2023, our anticipated NF to HCBS transitions will total approximately 606.**

- **Educating Members about supports available and helping them access appropriate resources.** For example, our partnership with Landmark Health spans seven counties and addresses Dual Eligible Special Needs Plan Members' temporary and transitional needs. Landmark's care model blends medical, BH and palliative care to treat the whole person. Landmark collaborates with PCPs when delivering in-home medical care. This partnership offers Members access to intravenous fluids, antibiotics, nebulizer treatment, real-time lab draws, catheter insertion and removal and acute wound care.
- **Monitoring and collaborating with Members in acute settings,** providing necessary resources until they are ready to return to their community or move to another level of care. This approach involves coordinating with external care teams to plan care and provide wraparound supports both pre- and post-discharge, helping eliminate SDOH and other barriers for an easy transition.
- **Coordinating transitional and temporary supports for families and caregivers** to help empower the people aiding Members. This includes caregiver coaching and peer support.
- **Contacting and engaging Members within one day of receiving notification of a facility admission.** This engagement drives proactive transition of care planning. We also complete a post-hospital assessment within 48 hours of discharge to verify the Member has a follow-up appointment and to assess for readmission risk. We follow each Member post-discharge to confirm they access appropriate follow-up care, including primary and specialty care. CHWs verify whether the Member completed their post-discharge follow-up appointment with the Provider within seven days.
- **Assigning a CHW to support any Member on an HCBS wait list.** The CHW helps the Member complete the Health Screening Tool (HST) and health risk assessment (HRA) and helps the Member access and maximize benefits, including preventive screenings and well visits. For Members under age 21, we advocate for the Member to access waiver-like services through Early and Periodic Screening, Diagnostic and Treatment (EPSDT). This support includes personal care and specialized medical care.
- **Partnering with Kansas stakeholders who promote temporary and transitional care.** For example, we have an agreement with Mission Health Skilled Nursing Facilities to accept Members who need a skilled NF stay and who are less likely to discharge from acute inpatient due to complex needs. We join weekly interdisciplinary rounds with Ascension Via Christi and KU Hospital staff to collaborate on discharge plans.

h. How the bidder's Care Coordination program interfaces with its disease management resources and activities.

Care Coordination and Disease Management Interfaces

At UnitedHealthcare, DM programs, both internal and external, are important components of our whole-person care coordination model. Members are identified and engaged for education in available DM programs through Impact Pro® risk stratification, screening and assessment and direct Provider referrals. When a Member in care coordination is identified as a good candidate for our DM program, DM is integrated as a component of each Member's tailored engagement and interventions. The DM care coordinator participates in the Member's IDT along with the Member and their lead care coordinator to develop integrated PCSPs. CommunityCare (our IT

platform) supports seamless integration of care coordination and DM into a single care plan as all DM case notes and care coordination notes are housed in a single Member case file.

For example, leveraging external DM programs such as the Diabetes Prevention Program (DPP) offered through the Kansas Department of Health and Environment partnership with Midland Health, Members are educated on the availability of these programs and referrals are sent on behalf of the Member. As of November 2023, we have referred 441 Members and are working with our partners to identify ways to increase engagement in this program.

Cancer DM Program Results

Our Cancer Support Program (CSP) is for Members who are preparing for or have already started cancer treatment. The CSP has a **98% Member satisfaction rate and is supported by UnitedHealthcare RNs with an average of over 15 years of experience in oncology.** These RNs participate in the IDT for any Member engaged in CSP.

i. The bidder's processes and systems that will be used to share and exchange information with those involved in the care and treatment of the KanCare Member to optimize integrated, longitudinal, whole-person care.

Processes and Systems for KanCare Data Sharing and Exchange

We have a demonstrated history of sharing and exchanging data in hundreds of ways to accommodate all our contracts today. For example, for the State's integrated health home program, OneCare Kansas Providers complete assessments that appear in CommunityCare. **For these Providers, we can offer role-based access to CommunityCare,** allowing for access to the specific information they need and so they too can see the data they are sharing in the Members' case files. We will provide training to all Providers so authorized users know how to use CommunityCare and leverage its potential to deliver longitudinal care.

As community care coordinators' roles expand, data sharing and exchange will be pivotal to avoid services duplication and promote timely access to shared clinical data. We have the staff, infrastructure, tools and resources in place now to promote effective information sharing and exchange. To support Providers with new requirements like this and improve data sharing and exchange, **we will use UnitedHealthcare's CMS-awarded IT infrastructure improvement funds to enhance data interoperability.** Our informatics and implementation teams, which have local and national staff and resources are ready to continue supporting the State's and stakeholders' needs as we implement the next phase of KanCare. We are actively collaborating with care coordination stakeholders to assess which data-sharing approaches will work for the new iteration of the program. We are committed to helping implement Provider-centric data-sharing approaches using our dedicated clinical practice consultants to partner with Providers to support effective data sharing and exchange.

Our flexible data-sharing capabilities can be tailored to each Provider's capabilities and preferences to make it easy to access the data within the Provider's workflow. The following table highlights several key systems that will support information sharing and exchange with KanCare Providers.

We also have existing agreements with health departments to share data as needed. We actively share care coordination details and the PCSP via CommunityCare, Providers' EMRs, shared clinical details via IDT meetings and via the Provider portal. In the five counties where we delegate UM and care coordination to Pediatric Care Network (PCN), we share data with the

Provider, including eligibility and health screening results. In turn, the PCN shares authorization data so we can pay claims accurately and on time. These are a few examples of our flexibility and capabilities when it comes to optimizing data sharing.

Data-Sharing System	Description
CommunityCare	Centralized, web-based care collaboration platform that contains claims data and promotes integration of medical, BH and social need supports by giving all IDT participants access to care plans. Provides automated notifications of care transitions. KanCare Providers may obtain role-based access to this system.
Point of Care Assist®	A module integrated into Providers' electronic medical record (EMR) through Fast Healthcare Interoperability Resources (FHIR) application programming interfaces (APIs) that offers real-time Member information for customized care insights and quality care opportunities.
Practice Assist	Workflow management tool that enables Providers and support staff to manage opportunities and conditions across multiple health plans through *UHCprovider.com* and direct EMR integration. Practice Assist offers practice-level HEDIS® quality measures and key capabilities such as viewing a Member's individual health record.
Partner Integration Hub	This EMR integration platform uses industry-standard protocols like HL7 FHIR to enable bidirectional data exchange for clinical activity, care plan, scheduling, claims, assessments, referrals, clinical risk and ADT alerts. This tool gives Providers access to a full suite of clinical data facilitating responsive care delivery.

j. The bidder's approach to monitoring and ensuring that KanCare Members receive necessary services, supports and resources necessary to improve individual and population outcomes.

Approach to Monitoring and Ensuring Appropriate Member Resources, Services and Supports

In accordance with **Scope of Services 1.0, 1.1, 2.36, 2.38, 4.0, and 7.4** we ensure KanCare Members receive necessary services, supports and resources needed to improve their health through the care coordination process along with the many other methods described in this response. Through care coordination and IDT support, Members develop their own PCSP, which includes necessary services, supports and resources to meet their individual needs and goals. The PCSP evolves as Members' needs and goals evolve. We monitor Member experiences, outcomes and care team performance to validate PCSP efficacy for both individual Members and across populations. To further track ongoing resource and service adequacy, we monitor clinical compliance using several methods:

Our Medicaid Operations Dashboard offers more than 70 reports with indicators to help manage daily clinical operations such as timeliness of Member outreach, care plan reviews and Member assessments. Care coordinator activities and productivity scores depicted on the dashboard allow us to evaluate the quality of care Members are receiving. We confirm Members get the time and attention they deserve by closely monitoring active caseloads and Member

assignments on the dashboard, supplementing data with Member assessments so our care team has the information they need to coordinate the best services. We monitor transition of care activities on the dashboard for Members who have an inpatient stay to prevent readmissions.

Our Clinical Pre-Post Tool determines the efficacy of a clinical program or intervention. This tool summarizes claims-based outcomes before and after care coordinator intervention compared to control groups of Members who were eligible for a program but who did not enroll. The tool includes demographic information such as race, ethnicity, age, sex and ZIP code. By comparing utilization data before and after an intervention, we measure changes in costs for a population and evaluate clinical outcomes including higher engagement with preventive care or BH therapies and reduction in high-acuity care or pharmacy utilization.

Our ongoing clinical program monitoring also tracks accuracy and comprehensiveness of clinical systems and processes that support adherence to all care coordination program requirements and goals. We perform analyses using propensity matching — or the creation of artificial control groups when randomizing is unethical or not logistically feasible — to isolate the impact of an intervention while controlling for confounding factors, including risk score, medical history and Member demographics. These analyses provide a deeper understanding of program efficacy for our Members. As Members move through their case life cycle — identification, outreach, assignment, enrollment and discharge — we connect with them regularly to provide timely support. Case life cycle key performance indicators such as average case length and enrollment periods are monitored.

We also monitor Member referral appropriateness and successes using our CQI program. CQI monitoring uses Plan-Do- Study-Act, longitudinal analysis and other methods to review ongoing program performance at individual and systemic levels confirming alignment with KanCare's contract requirements and program goals. Quantitative and qualitative data including Net Promoter Score (NPS) surveys; feedback from our Member Advisory Committee, Members, community partners and Providers; member services call monitoring; our NCQA chart audit report; PCSP reviews and HCBS-specific CAHPS survey results are all included in CQI.

Our care management outcomes data serves as a feedback loop to continually refine and evolve our processes and capabilities to best meet our Members' needs and goals. Outcomes data provides a population and subpopulation level view of progress toward keeping Members healthy and increasing Member engagement with health care activities and resources. We leverage many other methods to monitor and track care coordination activities. These methods include, but are not limited to:

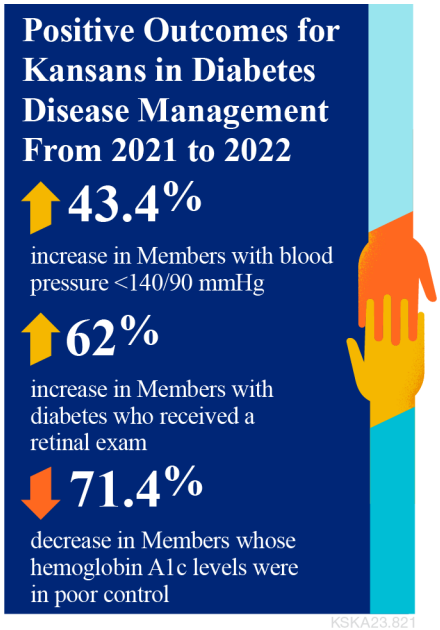
- **Care coordinator evaluations:** Managers conduct regular evaluations through one-on-one meetings and direct observation of care team interactions.
- **Patient profile analyses:** We use assessment data regarding Member health risk, chronic conditions and pharmacy claims (among many indicators) to monitor clinical activities.
- **Adherence monitoring:** We monitor adherence to required clinical periods for assessments and PCSP development in accordance with **Scope of Services 7.4.1 and 7.4.2.**
- **Inter-rater reliability testing:** We conduct regular training on State program care management requirements and assess adherence to KanCare care coordination processes through annual inter-rater reliability testing.

- **Analyzing performance drivers:** Membership characteristics, including condition prevalence, utilization patterns, race, ethnicity, language and urban and rural or frontier outcomes help our team understand performance drivers. We also use LTSS utilization reports to monitor overutilization and underutilization of services.

Informed by both ongoing Member care coordination dialogue and powerful analytics, we identify opportunities to improve care delivery so Members' choices, inclusion and personal goals are at the forefront of resource allocation.

Demonstrated Improved Individual and Population Health Outcomes

UnitedHealthcare demonstrates improved outcomes for Kansans, including those depicted in the image at right. The following care coordination **HEDIS-related improvement results are brief examples of how well our care coordination model works:**



- **Chronic Care Program Results:** Hypertension is examined using the percentage of eligible Members meeting the metric, "Controlling High Blood Pressure." **This percentage increased to 44.3% in 2022 from 27.3% in 2021.**
- **Preventive Care Program Results:** For Members accessing adult preventive services, colorectal cancer screenings increased from 43.8% to 48.7% and **breast cancer screenings increased from 45.8% to 50.6%.**
- **Acute/High-Risk Care Program Results:** For pregnant individuals engaged in Healthy First Steps within the first two trimesters **timeliness of prenatal care was more favorable at 52% compared to only 41% for Members eligible but not engaged in the program.** For those engaged in our high-risk maternity program, timeliness of prenatal care was 56% compared to a control group (unengaged) of 44%.

We look forward to working with KanCare and the State to continue demonstrating meaningful care coordination outcomes and program innovations that translate to the best health for all Kansans.

Integrated, Whole-Person Care

8. Community Health Workers (CHWs) and Community Health Representatives (CHRs) offer a unique and important role in outreaching, educating, and connecting KanCare Members to health care Providers, social service systems, and their MCO. Describe the bidder's approach to:

> "Having my CHW's support if I need it makes this program a safe space."
>
> *– Kansas Member engaged in CHW supports*

UnitedHealthcare values CHWs and their Tribal counterparts, Community Health Representatives (CHRs), and their unique capability to connect with individuals in a meaningful and effective way. Our CHWs are embedded within Kansas communities and understand the needs and reflect the values of Kansan communities, whether it is a struggling farming family in a frontier area or an individual dealing with a health condition in an urban setting. UnitedHealthcare CHWs have been serving their neighbors for over a decade. They know Kansas, and they love Kansas. Although CHWs and CHRs can fulfill the same type of role, CHRs specifically focus on Tribal communities. Their shared cultural background and knowledge of their community and resources is key to supporting Tribal Members and Tribal clinics. Our local experience, combined with nearly five decades of serving Medicaid and dual eligible Members across the country, enables us to use the best practice of including CHWs and CHRs as part of our care coordination team to outreach to and educate Members and connect them to health care and social services.

> "UnitedHealthcare has been a great advocate for the CHW workforce and has committed to provide funds for our CHW documentary, which aids to advocate for the important role CHWs play in our health care and social system. We appreciate UnitedHealthcare's support and look forward to continuing our collaboration."
>
> *– Sarah F. Kessler, PhD, MPH*
> *University of Kansas Medical Center*

We have worked to scale KanCare's vision of using CHWs and leveraging the work of Tribal CHRs to support nonclinical Member needs, improve access to care, facilitate healthy behaviors and improve health literacy by:

- Using CHWs and CHRs across the state to engage with Members in their communities and promoting further investment to multiply their efforts
- Defining clear roles and responsibilities and offering training and supporting certification of internal and external CHWs and CHRs
- Evaluating the success of Kansas CHWs and CHRs to improve individual care and outcomes, positively affecting population health

a. Utilizing and promoting the use of certified CHWs/CHRs as MCO staff and/or Providers located within local communities across Kansas

Utilizing and Promoting CHWs and CHRs Across Kansas

We use and promote CHWs and CHRs internally and externally. We include CHWs on our interdisciplinary team, promoting community CHWs and CHRs through partnerships and direct referrals, and providing them with training and resources.

Our Well-Established, Dedicated, Qualified UnitedHealthcare Team

We have 32 CHWs located throughout Kansas providing support to KanCare Members. Ninety-eight percent of our CHWs have lived in Kansas for over 20 years. We are committed to growing our internal CHW workforce and will add another 24 CHWs upon contract award to support the

additional in-person and telephonic touchpoint requirements. Our team of CHWs is diverse and highly experienced and serve all the State's counties. **Our CHW retention rate in Kansas is 88%, well over the industry benchmark median retention rate of 82%** from the 2022 Saratoga Benchmarking Survey.

Many of our CHWs have professional credentials that exceed the State contract minimum requirements, and five are certified through the Kansas CHW Coalition, which listed its first group of certified CHWs in July 2022. All currently employed CHWs will be certified by the end of 2024, and we will require any newly hired CHWs to obtain certification within their first year of employment.

Promoting CHWs and CHRs in Local Communities

In addition to the CHWs we have on staff, our care coordinators and Providers promote, assist and train CHWs working in CBOs, Provider groups and other nonprofits throughout Kansas and CHRs serving through the Indian Health Service. These relationships include groups serving faith-based individuals, communities of color, individuals with disabilities, immigrants and other diverse populations. Because of these authentic relationships, our strategies are reinforced in Kansas communities not just by UnitedHealthcare employees but by local CHWs and CHRs. Due to the trust we have established in these communities, our partners do not see a corporation; they see us — good people doing good things to make Kansans healthier.

To build relationships with local CHWs and CHRs and better understand how to link Members to community CHW and CHR services, our internal CHWs participate in community events such as the Tribal Health Summit by the Tribal Health Council. Since 2016, we have partnered with the council to provide resources and training for CHRs and Tribal Members on health and wellness and will collaborate with the council to execute expansion of the workforce for each tribe. We believe in the power of partnering with organizations in our communities to support them in a joint effort to make sure Kansans feel heard and respected and have their basic needs met.

Through local engagement, we meet long-term goals of improving access to care, reducing health disparities, facilitating healthy behaviors, enhancing public health funding and capacity, and supporting intentional systemic change. People coming together is the strength of our health plan. Some of our investments in local CHW and CHR efforts include the following:

- **CHW Coalition Symposium:** UnitedHealthcare sponsors this annual symposium organized by the Kansas CHW Coalition. We are proud members of the coalition and have been since 2016. **We will invest $150,000 in a scholarship fund for the Kansas CHW Coalition to provide training and certification for CHWs with at least $30,000 of this earmarked specifically for CHRs.**

- **Heartland Conference on Health Equity and Patient-Centered Care:** Since 2018, we have sponsored this conference, which focuses on CHW workforce growth and capacity. The conference unites academic health centers, CHWs, our Kansas faith-based community and CBOs to address health equity.
- **Community Health Council of Wyandotte County:** UnitedHealthcare funded one of the largest CHW programs for the State of Kansas in Wyandotte County. In 2016, we provided $1.6 million to the Community Health Council of Wyandotte County (CHC of WyCo) to join with clinical and community partners and launch the CHC CHW Program. The funds supported a multicultural team of six CHWs to serve the diverse community of Wyandotte for three years. The positive impact of our funding allowed the CHC of WyCo to secure further investments from local foundations. The CHC CHW Program was a key player during the response to the COVID-19 pandemic and today is one of the largest community-based CHW programs in the State of Kansas.

- **CDC Funding for CHW Workforce:** Our associate director of SDOH and maternal programs, Lucia Jones Herrera, works with the Kansas Department of Health and Environment (KDHE) and the University of Kansas Medical Center (KUMC) to guide and support the implementation of their CHW programs. KDHE and KUMC applied for and received funds from the CDC in 2021 to grow the CHW workforce in clinical and community-based settings. Ms. Jones Herrera has participated in multiple meetings with KDHE and KUMC leadership to share expertise and feedback on strategies, implementation and evaluation of these programs.
- **Communities Organizing to Promote Equity:** For Communities Organizing to Promote Equity (COPE), we provide support in the form of trainings and education, such as adult mental health first aid and housing navigation. We have committed $80,000 to support the program strategies through 2024. We are sponsoring and collaborating to create the COPE CHW documentary, *A Day in the Life of a Community Health Worker*.
- **Local Health Equity Action Teams:** We participate in COPE's Local Health Equity Action Teams to support community-based strategies and implementation. Activities we supported in 2022 – 2023 included:
  - Infant mortality summit in Shawnee mission
  - Food distribution in Bourbon County
  - A film premiere in Kansas City for the *Aftershock* documentary, which shines a light on the Black maternal mortality crisis in the United States
  - Water distribution efforts during the 2023 heat wave for homeless populations around the state
  - Hispanic Community Conversation Dinner in Montgomery County, which aimed to identify barriers for health care and healthy living for the growing Hispanic community

Maternal Community Health Worker Program in Sedgwick County

To address the poor birth outcomes in Sedgwick and Wyandotte counties, UnitedHealthcare invested in two CHW projects with the goal of addressing disparities and improving birth outcomes, which enabled helpful and collaborative partnerships. The innovative programs we support are described in the following sections.

In December 2021, we partnered with the KUMC Wichita Center for Research for Infant Birth and Survival (CRIBS) to develop the Maternal Community Health Worker (MCHW) pilot program designed to lessen adversities through community-based support to improve birth outcomes. Based on data showing that Members who reside in Sedgwick County, especially in urban ZIP codes, have higher rates of low birth weight and NICU admissions than Members in other parts of the state, the pilot launched in April 2022 with two full-time MCHWs from Sedgwick County who represent minority communities and were Medicaid beneficiaries in the past. Receiving CHW certification training at the Kansas CHW collaborative and additional training from CRIBS in maternal-specific topics, such as breastfeeding, pregnancy stages and safe sleep, the pilot combined the role of a doula with that of a CHW. The MCHWs provide support during and after pregnancy, including addressing SDOH needs. The KUMC Research Institute in partnership with UnitedHealthcare promotes the program to key clinical partners so they can refer Members. Members learn of the pilot through community events, mail and email. They connect with expectant Members, explain the MCHW program, obtain HIPAA-compliant consent and enroll them in the program.

> "My worker was great, and I have really enjoyed the [Sedgwick] program. She was always there to answer any questions that I had and went above and beyond. She helped me find many great resources in the community. She also really helped me with breastfeeding… pointing me in the right direction. Without my CHW's help, I would have given up. Thanks to her, I have been successfully breastfeeding for four months. Thank you for this opportunity!"
>
> – *Sedgwick UnitedHealthcare Member*

Through this one-to-one support, MCHWs assess each Member for educational and social needs, provide culturally appropriate support and coaching and connect Members to resources to address their needs. The MCHWs advocate for the Member, help them navigate the health care system and provide continual emotional and informational support related to a healthy pregnancy, labor and delivery, lactation support, coping skills and infant care.

In this partnership, our maternal care coordination team works with the MCHWs throughout the program. MCHWs contact our maternal nurses when there are clinical questions or concerns or when the Members need support with SDOH-related needs they have been unable to address with community resources. The care coordinators link the MCHWs to other UnitedHealthcare resources, including our housing navigator who works with the MCHWs to find resources for pregnant Members with complex housing needs, our employment specialist who collaborates with them to support Members with educational and employment needs and our food access coordinator who helps with food security.

Family Community Health Worker Program in Wyandotte

Recognizing the higher risk for negative birth and maternal health outcomes and disparities seen for Black Members, Indigenous Members and People of Color in Wyandotte County, UnitedHealthcare invests and promotes the CHC of WyCo and the Cradle KC initiative. At the beginning of 2022, we launched the Universal Maternal and Paternal CHW program. This

program instituted widespread prenatal care best practices in the area to begin closing the maternal and infant health equity gap. The initiative provides wraparound, place-based, barrier-free community-centric services aiming to close disparities and improve maternal and infant health.

Our teams work in tandem to serve shared Members and to support the initiative by participating in Cradle KC meetings alongside local health departments, local hospitals and other community organizations. Participating in the Cradle KC Collaborative meetings is important because these conversations provide a deeper understanding of the systemic issues influencing maternal and child health in the Kansas City metro area. Through participation in multiple stakeholder meetings, we noted the value of the Universal Maternal and Paternal CHW program and expanded our support to other programs to empower Black families in Wyandotte County, such as Black Dope Dads and Queen Village.

Empowering Black Families in Wyandotte County

- **Black Dope Dads:** This program was designed to educate, support and empower Black fathers to understand maternal, paternal and infant health; breastfeeding; and mental health. It trains them to support other Black men in their communities and encourage change.
- **Queen Village KC Metro Chapter:** This program seeks to improve birth and maternal outcomes for Black families by providing space for "a supportive community of powerful Black women who come together to relax, repower, and take care of themselves and each other."

Using Community Health Representatives in Tribal Health Centers

UnitedHealthcare serves more than 1,200 Members who identify as American Indian or Alaska Native. Members are affiliated with the Iowa Tribe of Kansas and Nebraska, the Kickapoo Tribe in Kansas, the Prairie Band Potawatomi Nation, and the Sac and Fox Nation of Missouri in Kansas and Nebraska. Our team connects with CHRs through common participation in the Kansas CHW Coalition and through other interactions, such as participating in Tribal events or meeting with Tribal representatives to understand more about barriers and the type of strategies we can implement to support their overall well-being. For instance, many Tribal communities follow holistic health practices, considering the entire spectrum of physical, mental, emotional and spiritual well-being and view health as a balance between these facets, integrating traditional medicine such as forest bathing and nature walks with modern health care approaches. Our collaboration with CHRs allows us to incorporate these holistic health practices into the person-centered service planning processes and improve engagement with our Members.

One example of our commitment to promoting CHRs is our support of Potawatomi Tribe's breastfeeding counselor, who is focused on improving breastfeeding rates among Tribal mothers and increasing the number of Indigenous birth workers in Kansas. We refer our American Indian families when they need culturally sensitive support. To increase the number of Indigenous birth workers in Kansas, we provided one of our Doula Scholarships to a Potawatomi Tribe breastfeeding counselor so she can serve our American Indian Members and other Indigenous families once she is certified. In addition, we are in the beginning stages of partnering with the public health specialist who serves the four tribes in Kansas. We are working together to share health resources and identify opportunities for collaboration.

b. Identifying the roles and responsibilities of certified CHWs/CHRs and providing the training necessary to support certified CHWs/CHRs to successfully perform their roles and responsibilities.

At UnitedHealthcare, CHWs have clear roles and responsibilities that include serving on Members' IDTs. We provide internal and external CHWs and CHRs opportunities for initial and ongoing training that enhances their ability to serve Members.

Roles and Responsibilities of Community Health Workers

Our CHWs are known for their empathy, resourcefulness, trauma-informed approach and capacity to engage individuals at multiple points in the system. Their deep understanding of community and populations' culture and beliefs allows them to be the perfect link between individuals and Providers. UnitedHealthcare's CHWs strengthen the health care system and function as an important part of the IDT. They help our IDTs deliver the right care in the right place at the right time and are an integral part in developing and implementing a Member's care plan. They also attend clinical case rounds, where they may self-identify as being a helpful resource to support the Member. A Member's care coordinator can engage CHWs to arrange and support the Member in accessing community-based services.

State CHW Core Competency	UnitedHealthcare CHW Roles and Responsibilities
Service Coordination and System Navigation	▪ Collaborate with the Member, family and health care Providers to coordinate quality care and services for the Member.
Education to Promote Healthy Behavior Change	▪ Engage Members either face to face or by phone to provide health and wellness information. ▪ Understand and communicate KanCare benefits, coverage limitations and regulations and apply them to the individual Member's needs. ▪ Support the Member's capacity to manage their own health and health care needs by increasing their health literacy.
Advocacy	▪ Advocate for Members and families so the Member's needs, choices and voice are fully represented when interacting with clinical and social services and when collaborating with the IDT. ▪ Speak up when Members struggle voicing their needs to Providers, utility companies, transportation services and others.
Effective Communication Strategies	▪ Reach difficult-to-reach Members both in person and by phone. ▪ Visit Members we cannot reach by phone at the Member's last known address. ▪ Leave contact information if the Member is not there. ▪ Search for alternative numbers by calling PCP clinics, pharmacies and other Providers shown in recent claims. ▪ Perform internet searches to find the individual.
Documentation and Reporting **Cultural Responsiveness**	▪ Assess, plan and implement care strategies that the Member and team develop. ▪ Direct the Member toward the most appropriate, least restrictive level of care.

State CHW Core Competency	UnitedHealthcare CHW Roles and Responsibilities
Individual Assessment	▪ Work with the IDT to use company and community-based resources to establish a safe, effective and culturally appropriate care plan for Members. ▪ Help the Member set person-centered, strategic and measurable goals in the care plan. ▪ Coach the Member in achieving those goals through regular follow-up calls and ongoing documentation of progress toward the goals.
Individual and Community Capacity Building **Use of Public Health and Community Health Concepts and Approaches** **Community Assessment**	▪ Work with local CBOs to link Members with services to wrap around their KanCare medical benefits. ▪ Connect Members to resources through closed-loop referrals to social service programs, including financial, psychosocial, community and state supportive services. ▪ Use the Findhelp referral tool to find the most appropriate SDOH supports for Members.

The connection to community resources for nonmedical SDOH needs is a key attribute of our CHW program. The Findhelp SDOH referral platform that we have been using since 2020 has closed-loop tracing capabilities, which are instrumental in the referral and tracking process. The system provides the CHWs data and analytics to determine whether the referral was successful. If not, they can find alternate services for the Member. Our CHWs have built close relationships with resources in community, and many times they reach directly to those contacts to help fulfill Member needs.

- **Housing:** Our CHWs work closely with our dedicated housing navigator. When CHWs have a specific Member housing need, they engage with our housing navigator to address it. They directly help Members navigate Section 8 qualifications to obtain public housing, senior low-income housing and income-based housing listings. Our CHWs help Members into Eileen's Place and Hillcrest Transitional Housing, which provides individuals and families with a secure, safe and stable home. Eileen's Place is a 60-unit community of supportive housing for families with children in Kansas City, Kansas, where Members find a home that is safe, comfortable and stable. Hillcrest Transitional Housing has five residential sites in multiple counties where Members receive rent- and utility-free housing while seeking and maintaining full-time employment and attending life skills classes.

Assisting with Costs of Living

One of our CHWs met a Member in their home. Our Member lives with legal blindness and had lost his wife and his dog and was behind on rent and very depressed. Together, they completed the Kansas emergency rental assistance application, and the Member received 15 months of rent and utilities paid. The Member was so grateful to be able to stay in his home, and without the stress of being behind on his bills he was able to reconnect with friends at his church.

- **Food:** Our CHWs connect Members to UnitedHealthcare food value-added benefits and other local food resources. One CHW shared how rewarding it was when Members hear for the first time that they can access a Supplemental Nutrition Assistance Program or electronic benefit transfer card to buy $5 worth of fruit and get another $5 back to buy more fruits or vegetables of their choice, up to $25 a day.
- **Bills:** Our Members can search the internet or use Findhelp for resources for assistance with rent and utilities, but navigating the paperwork and processes to obtain that assistance can be overwhelming. Our CHWs can meet with Members in a location of their choice and help them work through the process. They connect Members with the Low-Income Energy Assistance Program, a federally funded program that helps low-income eligible households pay a portion of their home energy costs. They search for opportunities together on *www.needhelppayingbills.com* or call utilities companies together to restore services or negotiate a payment plan.
- **Education:** Education can lead to employment and increased income for our Members. Our CHWs work with Members to understand their employment and education needs and connect the Members to supports and resources in their communities. CHWs frequently consult with the UnitedHealthcare employment and education specialist to access the UnitedHealthcare education value-added benefit. This value-added benefit is $200 per Member per year to obtain education that will support employment, such as GED or medical coding classes, or to help cover the cost of books.
- **Transportation:** Our CHWs go beyond giving a phone number to Members to schedule rides to their appointments. Our CHWs understand Member needs extend beyond a ride. We have navigated Members through scheduling long trips requiring overnight lodging, helped a Member schedule a flight to get to a specialty appointment and helped Members download and use our reimbursement mileage app.

CHW Helping a Family's Infant Care Needs

In July 2022, Kimberly, one of our Wichita CHWs, began working with a 31-year-old pregnant Member. In September, the Member contacted Kimberly to inform her that following a car accident she was now in preterm labor and struggling with preeclampsia. She shared she needed a car seat and was having difficulty paying for utilities.

On behalf of the Member, Kimberly partnered with several Sedgwick County community organizations, including the Kansas Birth Justice Society, KERA, Center of Hope and Salvation Army. Through collaboration with these agencies, Kimberly was able to get the utility bill paid and have a new car seat-stroller combo set, diapers and baby clothes delivered to the hospital before the Member and newborn were discharged. In October, the Member notified Kimberly that she had delivered her baby and that they were both home and doing fine. The Member expressed how grateful and appreciative she was.

CHW Helping a Member with Cancer

Our CHW enrolled a Member who needed ongoing, repeated radiation treatments for cancer. The Member was overwhelmed with fear, had limited natural supports and had no access to transportation. The Member was confused about scheduling all the appointments and the transportation. The CHW personally arranged rides for the Member so they could complete the radiation treatments. The Member reported back to the CHW that they are now cancer free.

Necessary Training to UnitedHealthcare CHWs and Other CHWs and CHRs

Our internal CHWs go through comprehensive internal UnitedHealthcare training, including health equity training, and they access external learning opportunities through partners such as the Kansas CHW Coalition. We extend our training courses to external CHWs and CHRs.

UnitedHealthcare Community Health Worker Training and Education

Our CHWs serve UnitedHealthcare Members by deeply understanding the needs, cultures and available social services and resources of the Kansans they serve. We spend time equipping our CHWs with skills that help our Members live better lives. UnitedHealthcare offers CHWs the same trainings our care coordinators take. We begin by meeting contractually required training requirements with each CHW completing the required trainings as defined in **Scope of Services 7.4.9**. We then offer ongoing optional education opportunities in our online self-paced Care Management University that go well beyond contract required trainings. The CHWs complete 25 additional self-paced courses on topics such as motivational interviewing, stages of change, smart goal setting, caregiver support, advance directives, specific health conditions, diversity and inclusion and company-specific technology.

In addition, new staff attend a 10-day instructor-led training before interacting with Members. We believe in the power of mentoring as a training tool. Therefore, each new staff member is assigned a mentor as the main point of contact to guide them through their new hire experience and training for their first 90 days after their instructor-led training. The mentor makes joint calls to the Member and Providers, reviews their documentation, listens to calls and is a resource for questions as the new hire gradually becomes independent in their new role. Annually, they take at least 18 courses above the contract required trainings to refresh their skills. UnitedHealthcare managers track and document each CHW's training progress and needs through our MyLearning platform.

100% of CHWs have completed and earned their first of four badges in Health Equity Foundations.

KSKC23.888

Beyond contract requirements, all our CHWs have completed and earned their first of four badges in our 2023 Health Equity Foundations course through Care Management University. Through this course, CHWs gain an understanding of the impacts of health inequities on our Members, which drives our focus and resources toward targeted individualized care that centers on what is important to the Member.

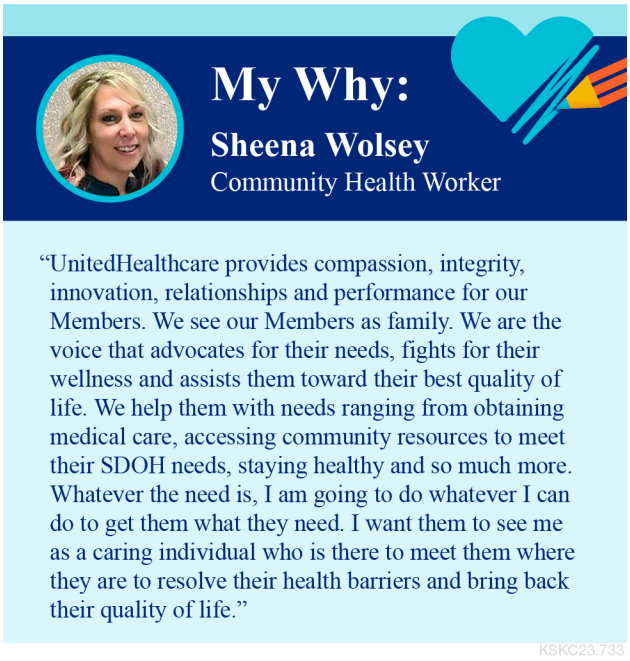
In addition, CHWs participate in KDHE's monthly motivational interviewing open practice sessions, which offers them a chance to share challenging situations, problem solve with other CHWs and leave feeling prepared and confident to have meaningful conversations with Members. The motivational interviewing sessions have been helpful, and we have adopted the concept for ongoing, regular training with CHWs to better enhance our ability to help Members reach their goals through motivational interviewing techniques. For example, our maternity engagement had a 29% improvement from 2022 to 2023.

We provide training on our internal systems and tools so that CHWs can effectively address Member or Provider needs. Our systems include CommunityCare, our electronic integrated care management system, which houses care coordination assessments and care plans and allows care coordination staff to access claims history; our integrated UM system that includes authorization information for all levels of care; and Maestro, our integrated member service desktop solution,

which allows our advocates and agents to focus on the Member, removing the need to navigate in multiple systems to answer a Member's questions.

CHWs have training in Provider tools, including Kansas Medical Assistance Program, the State's web-based Medicaid enrollment system; Kansas Health Information Network, the Provider-led statewide health information exchange; and the Kansas Aging Management Information System, the State's web application to collect data on Member assessments, plans of care and services provided under aging programs.

Our CHWs can access various educational opportunities where they can engage in learning modules reinforcing trauma-informed care; health equity; mental health first aid (MHFA); and how to recognize abuse, neglect, exploitation and SDOH barriers. Some of these modules offer continuing education credits (CME/CEU/CCM) and cover diverse topics such as addressing maternal mortality and caring for the LGBTQ+ community.



Training and Certification Efforts for External CHWs and CHRs

We have long been a champion for CHW and CHR capacity and workforce growth in Kansas. Our director of SDOH and maternal programs, Lucia Jones Herrera, has participated on the Executive Committee for the Kansas City Regional CHW Collaborative since 2015 and on the Kansas CHW Coalition since 2016. Both groups seek to increase CHW and CHR capacity to support vulnerable communities in Kansas.

UnitedHealthcare has been invited to share our expertise with community health partners by providing training and education resources to external CHWs and CHRs. For example, we provide support to the CHWs and CHRs from the COPE program, including trainings on MHFA, housing navigation, Medicaid renewals, Medicaid eligibility and SDOH.

By providing CHW trainings to facilitate certification and scholarships to pay for certification fees, we will enhance CHW and CHR workforce development in Kansas and, in turn, enhance Member experience, satisfaction and health outcomes in our communities.

c. Measuring, monitoring, and evaluating whether certified CHWs/CHRs are effectively fulfilling their roles and responsibilities to improve Member care, individual outcomes, and population health.

Our Members are healthier because of the efforts of CHWs and CHRs. We use quantitative and qualitative data to measure outcomes, monitor program effectiveness and evaluate the impact of our human and financial investments.

Monitoring Internal Performance of Community Health Workers

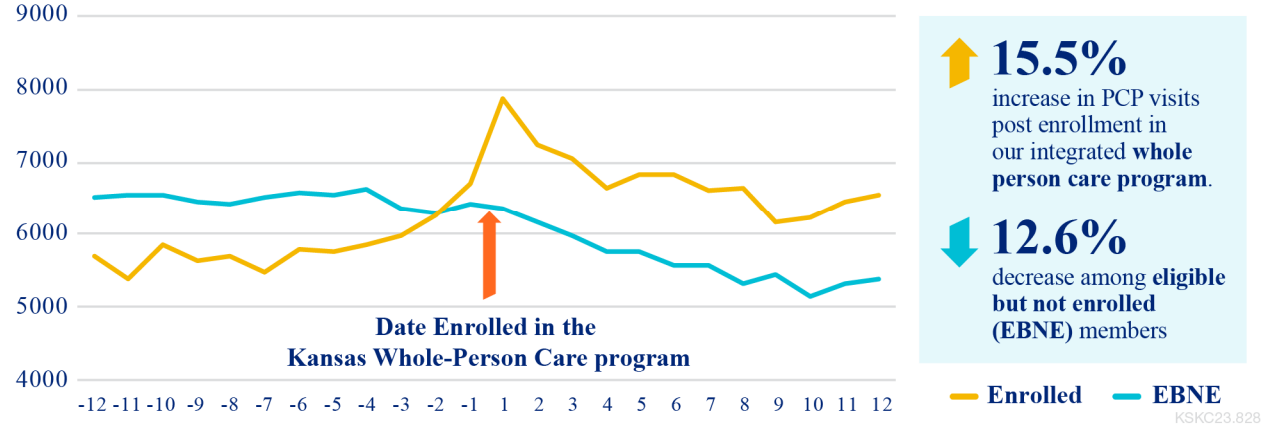
As part of our employee performance management process, our CHW managers perform a monthly audit of each team member's productivity. The Productivity Dashboard reports on their call and field visit volume, number of monthly enrollments into care coordination and caseload volume. The managers audit the CHW files monthly to monitor care and documentation quality and adherence to timelines. The team uses this information for regular coaching, goal setting, retraining and for the midyear and comprehensive annual review. For example, prompt contact to confirm Members understand discharge instructions and new medications and have a follow-up appointment scheduled with their PCP is critical in avoiding readmission. Our CHWs are required to contact Members within one business day of notification of a discharge. We monitor completion of this outreach and have 90% compliance with this requirement.

Managers complete call calibration audits of CHW calls with Members. Managers record and review CHW calls to identify opportunities for coaching or additional education. The managers share best CHW interaction practices with other members of the team.

Measuring Impact of Our CHWs on Member Outcomes

Our Clinical Pre-Post Tool measures the impact of CHWs on Members' health and wellness outcomes through claims-based outcomes before and after the intervention to compare to ready-made control groups of Members eligible for the program who did not enroll. The tool includes demographic information, such as race, ethnicity, age, sex and ZIP code. We measure changes in costs for a population and clinical outcomes by comparing utilization data before and after an intervention. Comparing outcomes to the experience of Members who did not participate in the intervention allows us to control for natural regression or trends affecting the entire state or population and not attributed to the clinical program. We perform analysis using propensity matching — or the creation of artificial control groups when randomizing is unethical or not logistically feasible — to further isolate the impact of an intervention while controlling for confounding factors, including risk score, medical history and Member demographics. In Kansas, Members engaged with CHWs have a **15.5% increase in PCP visits post-enrollment** in our integrated whole-person care program compared to eligible but not enrolled Members who experienced a decrease of 12.6%.

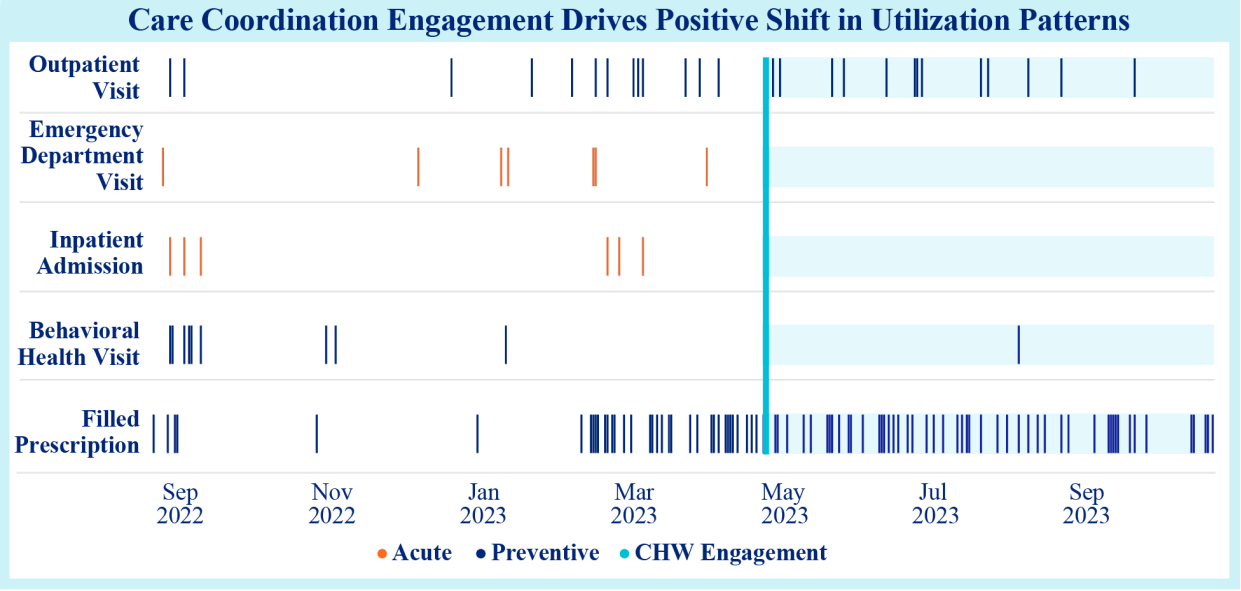
Figure 8-1. Clinical Pre-Post Tool



Given disparities in Black Members' birth outcomes, in 2022, we enhanced our maternity care management team by assigning CHWs to support rising-risk Black pregnant Members. Early year-over-year results from before and after this change show improved outcomes among Black Members, **including an increase in engagement from 15.69% in 2021 to 21.23% in 2022, and a decrease in NICU admissions from 11.07% in 2021 to 8.92% in 2022 (representing a 35% increase in engagement and a 19% decrease in NICU admissions).**

We also use our internal data capabilities for a point-in-time view of individual Member utilization and to better understand program effectiveness on an individual level. Hotspotting contains Member conditions, utilization and contact information so care coordinators can directly follow up with Members to address needs or deter inappropriate utilization. Depicted in the following figure are trends in utilization for individual Members before and after an intervention began. Each notch represents an instance of the Member seeking those services. As the figure shows, after engagement in the program (represented by the bold line and shaded area), the Member sought outpatient behavioral care, filled their prescription more frequently and had fewer inpatient stays.

Figure 8-2. Member Utilization Trends



Evaluating Impact of External CHW and CHR Projects

We perform similar analyses on programs for which we partner with other organizations and programs that we subcontract to other organizations. When partnering with local organizations, we collaborate on program evaluation. We jointly determine the right metrics and then connect at least quarterly to monitor the

progress toward those program goals. Some of the basic data we ask our partners to collect includes:

- Number of individuals who participate in the program
- Demographics of the participants
- Performance toward program goals, including:
  - Attendance
  - Individual goal achievement
  - Referrals to other health or SDOH programs
  - Participation rates
- Surveys on individual satisfaction with the program and CHW support

Impact of Maternal Community Health Worker Program in Sedgwick

Our collaboration with the KUMC CRIBS Sedgwick program showed early successful outcomes. The goals the KUMC CRIBS program set were as follows:

- The CHW screens participants for adverse SDOH on their first trimester encounter and periodically during the program.
- Participants attend their first prenatal visit within 42 days of pregnancy or Medicaid assignment.
- Participants participate in prenatal and labor classes.
- Each participant participates in 90% of prenatal visits.

Between April 1, 2022, and June 30, 2023, **87 participants engaged with the MCHW program and started enrollment paperwork** (e.g., consent form, demographic form). Of those, **91% remained engaged in the program until delivery**.

To evaluate the impact of the Sedgwick program, our team used a control group that did not receive this type of support. The analysis shows the following:

- The MCHW pilot program group were **62% less likely to have C-sections** compared to those not participating in the pilot.
- The average **number of days the mother spent in the hospital after birth was 8% shorter** in the MCHW program group compared to the control group.
- The MCHW pilot program group had **0% low weight birth prevalence** compared to 7.8% for those not participating in the pilot.
- The MCHW pilot program group had a **0% NICU rate**, compared to a 12.8% NICU rate in the control group.

Although data analysis shows exciting and promising results, it is important to note that the sample size of the MCHW program in Sedgwick is minor compared with the control group used for the analysis. These are initial outcomes. We continue to evaluate these efforts to measure the impact and effectiveness of this type of care model and partnership.

Impact of Community Health Council of Wyandotte County

The program goals of the CHC of WyCo program are to:

- Reduce preventable sleep-related deaths
- Decrease maternal smoking
- Increase prenatal care utilization

Because the Wyandotte County program serves families who both do and do not have public insurance coverage, and therefore do not differentiate between our Members and those of other payers, we cannot evaluate actual KanCare birth outcomes. Overall outcomes, as published in their annual report, include the following:

- Screened 1,304 clients for SDOH and social risk factors
- Reached 200 families while the individual was pregnant
- Conducted over 250 EPSDT screenings
- Provided more than 250 car seats, 200 Pack ’n Play playpens and over 12,500 ounces of formula to families
- Conducted over 4,000 client encounters or visits
- Helped 300 families develop a reproductive life plan to encourage spacing between pregnancies, which reduces the impact of unintended pregnancies on individual and family health

This project and our other efforts in Wyandotte County reduced our percentage of NICU births from **11.73% in 2021 to 7.31% in 2022**.

Continuing to Use Data to Increase CHW and CHR Impact

Analysis of our birth outcomes data for 2022 revealed an increase in NICU rates. For our Hispanic population, the rate increased from 7% to 9%. For our American Indian Members, the rate increased from 2% to 20%. Through our CQI process, we implemented new strategies to address these populations, including:

- Assigning high-risk Hispanic pregnant Members to our Spanish-speaking nurse for care coordination support to remove communication barriers and support cultural preferences
- Supporting our American Indian families through hiring representatives from their tribes, such as the lactation consultant

Our goal is to reduce the NICU rate by 10% for calendar year 2024.

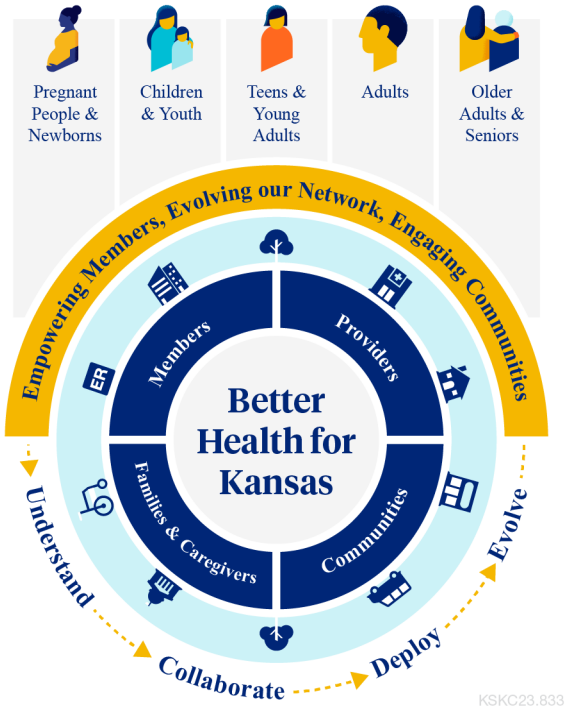
Investing in community-based CHWs and CHRs and integrating CHWs as part of our interdisciplinary team approach, leads to improvements in health outcomes, Member satisfaction and access to SDOH supports. UnitedHealthcare will continue hiring CHWs across the state to engage with Members in their communities and investing in community CHWs and CHRs to multiply their efforts. We will train and support certification of internal and external CHWs and CHRs so they can join us in efforts that produce measurable population health impacts.

Integrated, Whole-Person Care

9. Describe the bidder's top three (3) strategies for advancing integrated, whole-person care for its KanCare Members and how the bidder will measure, monitor, and evaluate the effectiveness of the strategies.

Advancing integrated, whole-person care requires managing the whole spectrum of a Member's health and health-related social needs based on individual experiences, preferences, barriers to care and conditions. These needs evolve over time and can be affected by cultural, familial, community and regional nuances. UnitedHealthcare uses population health management (PHM) nationwide as a best practice to advance integrated, whole-person care. PHM involves the systematic collection, analysis and application of population data to improve health outcomes and facilitate coordinated care across physical, mental and social services, ensuring all aspects of a person's health are considered and addressed. This approach allows us to draw on carefully studied results and lessons learned not only within Kansas but in every other state we serve.

Figure 9-1. Our Population Health Management Strategy



Grounded in PHM, UnitedHealthcare's top three strategies for advancing integrated, whole-person care for KanCare Members are:

- ***Empowering Members'*** physical, behavioral and social health and wellness
- ***Evolving our network*** and the Health Care Delivery System
- ***Engaging communities*** to drive optimal health outcomes for all

Implementing these strategies has resulted in improved whole-person health outcomes and helps make sure our Members receive the most appropriate level of interventions to meet their whole-person care needs. Our consistent HEDIS® performance is evidence of the effectiveness of our model. We have placed first in quality since 2014. In the most recent measurement year, we finished first in 77% (10 out of the 13) KDHE pay-for-performance measures. Among other areas we excelled in diabetes control, **exceeding the Medicaid 75th percentile for three key diabetes HEDIS measures** — Blood Pressure Control for Patients with Diabetes, HbA1c Good Control (<8%) and Diabetic Retinal Eye Exams In addition, from 2021 to 2022, **Members with diabetes experienced a 24.4% reduction in inpatient admits per thousand and a 11.3% reduction in emergency department (ED) visits per thousand.**

Strategy 1: Empowering Members' Physical, Behavioral and Social Health and Wellness

UnitedHealthcare's PHM program empowers Members and their families to manage their health and wellness needs through the full spectrum of covered, noncovered and expanded benefits. Our approach offers initial and ongoing Member education; DM tools, resources and programs; and enhanced care coordination services for Members with complex conditions.

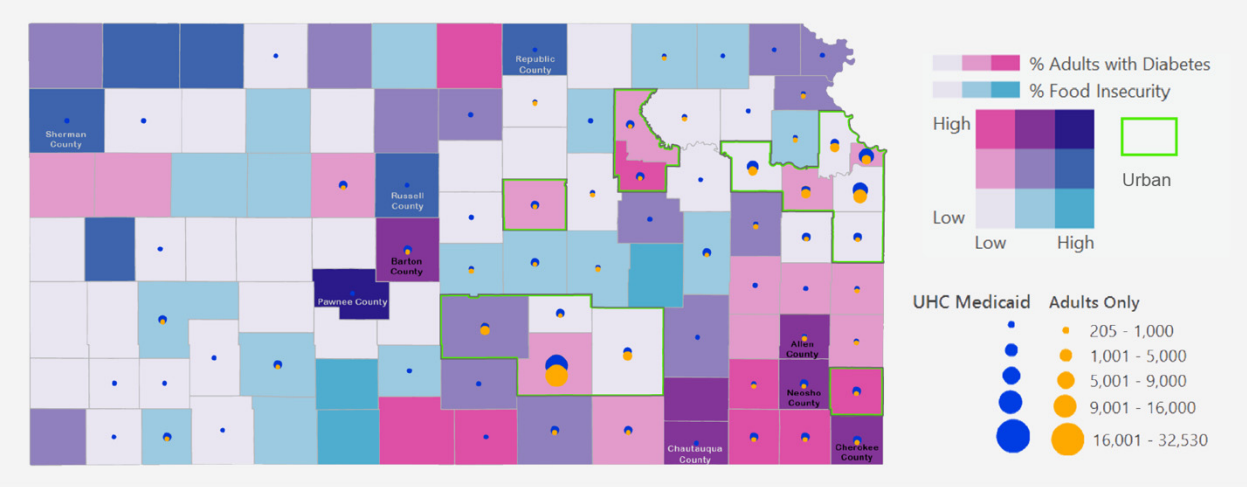
Using Data-Driven Approaches to Empower Members' Whole-Person Health

We use several methods to identify the unique needs of our Members and stratify our Member population into risk levels, so we can provide the most appropriate type and level of intervention to promote Member health and well-being. We outreach to 100% of our Members to complete the HST. Of those we reached in 2023, 91% successfully completed the HST. When we identify a need through the HST, we immediately connect Members to appropriate resources to meet those needs. For example, we connect Members who identify as using tobacco and express a desire to quit to tobacco cessation resources such as KanQuit. The HST may suggest a need for further integrated assessments such as the HRA, which further identifies the Member's whole-person needs to help stratify and link them to one of our chronic condition management or care coordination programs. If the HRA reveals needs such as an acute risk for self-harm, we immediately connect the Member to BH crisis services.

We use industry-leading tools and strategies to stratify and segment our Member populations. These systems have been refined across all 32 states plus the District of Columbia where we serve Medicaid, CHIP and D-SNP Members. The tools allow our teams to respond to Member needs and opportunities, partner with Providers and CBOs and use data to identify opportunities to improve health outcomes and address social needs at both individual and population levels. The design of the tools embeds health equity considerations to identify groups that may have a greater need. Key capabilities include:

- **Hotspotting tool:** A multifaceted, dynamic, on-demand tool used to quickly identify Members who need intervention and guidance toward evidence-based treatment or community supports to address SDOH. We can zoom in and out at programmatic, population and individual Member levels to inform program initiatives that improve Member health outcomes and address health disparities. Care coordination staff select from a menu of special conditions and social factors with list or heatmap viewing to implement Member-specific activities. The example overlays adults with diabetes and those with food insecurity. This visual allows us to geographically pinpoint where to target our interventions to address food insecurity and diabetes management.

Figure 9-2. Kansas Food Insecurity and Diabetes



Empowering Members by Increasing Health Literacy and Health and Wellness Education

Health literacy promotes self-care and preventive behaviors, empowering Members to make informed decisions about their health and grasp the interconnectedness of their physical, mental and social well-being. This awareness includes understanding medical information, navigating health care systems and communicating with health care Providers. To facilitate Member empowerment, we design and distribute easy-to-understand health information materials with clear calls to action tailored to the cultural needs of our Members. For example, in the Fight the Flu article in our 2023 Fall *Health Talk* newsletter, we included a link to our online flu shot locator tool. In addition to receiving them through mailings, email and texts, Members can easily access these materials through our Member portal on *myuhc.com* and our mobile app.

We use digital platforms to disseminate health information, offering interactive and personalized learning opportunities. These platforms often use multimedia such as videos, animations and infographics to explain complex health concepts in a more engaging and understandable manner. We listen to Member feedback on our digital resource and continually update them to increase ease of use. As a result, our **year-to-date digital engagement has increased 295%, and logins to our mobile app are up 533%.** Interactive tools available on our Member portal include:

- **Whole Health Tracker:** Used by Members to identify their goals, interventions and ways to self-manage their physical and BH needs. It includes our Wellness Wheel and Toolkit, an easy-to-use resource to create a complete picture of their wellness journey progress.
- **Personal Care Checklist (PCC):** Available via the *myuhc.com* digital Health and Wellness page, the PCC is a dynamic list of the Member's clinical "to-dos" tied to their needs. The PCC includes over 30 recommendations, including annual wellness exams, BH and emotional well-being steps, and vaccinations. Claims-based algorithms built into our Member communications platform help guide Members to the right PCC and provide tailored educational content explaining the "why" and "how often."

UnitedHealthcare developed an extensive array of value-added benefits that incorporate our Members' whole-person care needs and empower Members to engage in healthy behaviors. Examples include rewards for Members to advance their education or work-related training and

attend work-related activities to promote their independence, incentives for Members to engage in preventive care such as dental screenings, well-child visits and perinatal care and incentives for pregnant Members to engage in in-home care coordination support. In 2023, we expanded our rewards programs, which **increased the number of visits receiving incentives by 397% from 4,599 in 2021 to 22,864 in 2023**.

Empowering Whole-Person Health through Disease Management and Care Coordination

Using data-driven risk stratification and Member segmentation tools, we identify the most appropriate holistic DM program or integrated care coordination for each Member based on program intensity and person-centered needs.

Members with chronic and complex health care needs often face significant challenges in navigating the health care system and community-based resources needed to improve their whole-person health outcomes. UnitedHealthcare's care coordination programs are designed to address these barriers — providing Members with a primary point of contact, their care coordinator, who is supported by a local, integrated IDTs of BH specialists, Community Health Workers, pharmacists and SDOH specialists. Our IDTs live in the communities they serve and are experts on the local resources available to Members living in the area.

Empowering Andrew's Whole-Person Health

Andrew is an adult with autism who has sensitivity to touch and is nonverbal. In 2019, his dentist stated he had six chipped teeth requiring crowns. Later, dental care professionals identified a need for root canals in five teeth. Our care coordinator Bridget took charge of getting him the care he needed in a format that was sensitive to his needs. She found an endodontist who would accept all three of his insurances and perform the root canals under anesthesia. She found the one endodontist in Eastern Kansas who makes same-day crowns and a traveling Dual Eligible Special Needs Plan anesthesiologist who could assist. (Temporary crowns require multiple visits. If one falls out, Andrew would be unable to tell anyone and would likely swallow it, causing further harm.) Bridget located a grant to pay for the noncovered services and coordinated all three insurances. Andrew got through the procedure like a champ and now shows off his smile to nearly everyone in his path.

From Andrew's mother: **"Bridget is our heroine. We have had close to a thousand professionals who have worked with Andrew over more than 30 years. Rarely do you find someone [like Bridget] who acts with as much passion and intensity as a parent. [She is] someone who doesn't quit and sees every challenge through to resolution."**

KSKC23.911

With input from the IDT, the care coordinator assists Members in developing a comprehensive care plan that addresses all aspects of their health and connects them with Providers and community-based resources to meet the Member's whole-person needs. With Member consent, we share the care plan with the Member's Providers via our Provider portal. Care coordinators prepare Members for appointments, help the Member connect with the Provider and work with IDT members like our employment specialist to help a Member locate and respond to employment opportunities.

Members enrolled in our DM programs receive targeted interventions that equip them to actively manage their conditions in conjunction with their other whole-person needs. For example, our Cancer Support program (CSP) provides holistic support for Members who are preparing for or have already started cancer treatment. The CSP links Members to an integrated team that includes RNs specializing in oncology, social workers, pharmacists and a medical director. Members enrolled in CSP have an average of five RN interventions per month. The nurse collaborates with the treating oncologist to address uncontrolled symptoms, nutrition needs and disease progression. Our nurses provide education regarding diagnosis, treatment, symptom management and palliative care. From December 2022 to July 2023, KanCare Members engaged

in CSP (compared to those eligible but not engaged) saw **11% fewer ED visits and 17% fewer unplanned admissions and readmissions.**

Strategy 2: Evolving Our Network and the Health Care Delivery System

We partner with stakeholders across Kansas to continually evolve the care delivery system to enable Providers to deliver integrated, whole-person care. We offer a systematic approach to support Provider practice integration, including value-based purchasing (VBP) models and tools, education and support from Provider-focused consultants.

Provider Value-Based Purchasing to Promote Integrated, Whole-Person Care

VBP models incentivize Providers to offer more holistic services, including pharmacy, specialty, BH and SDOH that focus on the overall health outcomes of Members. Linking payments to quality of care encourages the provision of comprehensive, coordinated services. Our Provider VBP agreements include incentives designed to promote integrated, whole-person care:

- **Episodes of Care (EOC):** In 2022, we expanded our VBP suite to include EOC incentives for specialists focused on high-cost conditions and procedures and reducing health disparities. We have 11 Providers in Kansas enrolled in our asthma, maternity and diabetes EOC programs. **Nationally, early results of our 47 active maternity EOCs across 13 states show a 4% to 6% reduction in cost and 2% to 4% reduction in C-section births.**
- **Community Plan Primary Care Professional Incentive (CP-PCPi):** [redacted]
- **BH Provider Incentive (BHPi):** [redacted]
- **Health Equity Provider Incentive (HEPi):** [redacted]

> "UnitedHealthcare has supported our organization in providing integrated care to our patients and meeting community needs through a variety of collaborative partnerships, such as participating in our outreach efforts, working together through data sharing and innovative approaches to close gaps in care and improve health outcomes for KanCare Members, contributing to our food pantry by funding refrigeration, and facilitating knowledge and data sharing on Medicaid PHE Unwinding, [as well as] strong collaboration on the OneCare program."
>
> *– Teresa Lovelady, President and CEO HealthCore Clinic*

Tools, Training and Resources Supporting Provider Integration

Educational tools and practice management support enable Providers to deliver integrated care. We train all Providers on best practices related to integration, regardless of whether they are PCPs, BH Providers or Providers from specialty areas. Through our Provider portal and our

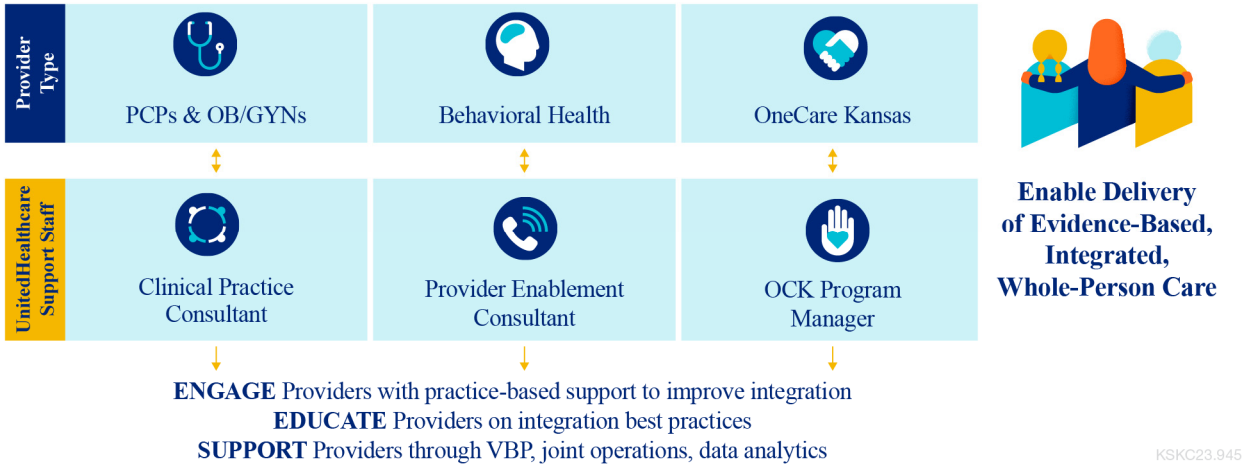
dedicated field-based staff, we provide on-demand trainings and resources that support integrated practice. We provide them with dependable data tools to track Member health care needs. Our tools help expand Providers' ability to integrate their practices and increase overall Provider buy-in and accountability.

Tool	Description of Tool
Provider Training Tools	
BH Toolkit for Medical Providers	Gives Providers access to Clinical Practice Guidelines, screening tools, best practices and resources to identify and treat individuals with BH conditions within their primary practice.
SDOH Considerations for Network Providers	Delivers Providers an understanding of SDOH, tools for identifying SDOH needs and guidelines for addressing these needs.
Optum Health Education™ Trainings for Providers	Gives Providers and their staff access to accredited, on-demand free continuing education covering a variety of topics related to integrated, whole-person care. **In 2022 and 2023, 360 Kansas Providers completed 1,851 courses, earning 2,426 credits.**
Provider Data Tools	
Point of Care Assist® (POCA)	Provides real-time information, such as care gap closure and treatment referral options through a multi-payer integrated EMR.
Technical Support for Federally Qualified Health Centers (FQHCs)	Offers FQHCs a UnitedHealthcare-designed dashboard containing health information about their panels. It includes information on utilization trends, diagnostic and condition-specific information, demographic and SDOH information.
RubiconMD	Connects PCPs to specialists at the patient point of care. The tool helps PCPs decide if they need to make a referral and provides e-Consult support tailored to Member needs.

Local Field-Based Staff Help Providers Advance Integrated, Whole-Person Care

As outlined in the figure, we have a team of Kansas-based, Provider-facing staff dedicated to assisting Providers in PHM activities. They present detailed data analytics and clinical insights to enhance care coordination approaches and provide education and tools to help enable the delivery of evidence-based, integrated, whole-person care. Our RN clinical practice consultants meet with high volume practices engaged in VBP arrangements and their office staff to review their performance on health plan and HEDIS goals. They review associated Clinical Practice Guidelines and identify opportunities to improve the practice's whole-person care BH and physical health integration services. We support our BH Providers in the same manner. Our provider enablement consultants are BH clinicians who assist BH Providers with improving individual and population outcomes, delivering whole-person care and integrating physical health and BH. To support OneCare Kansas (OCK), we assigned a dedicated OCK program manager (PM) who acts as a single point of contact for OCK Providers. The OCK PM provides frequent technical assistance to OCK Providers on issues such as billing and claims.

Figure 9-3. UnitedHealthcare Field-Based Provider Support



Strategy 3: Engaging Communities to Drive Optimal Health Outcomes for All

Catalyzing connections unlocks potential. We listen, learn and link community, Provider, MCO and State partners to collectively improve coordination of and access to person-centered, holistic care. Our strategy to increase individual and community-based access to integrated care that addresses barriers to care and incorporates SDOH includes (1) community education and awareness efforts and (2) community infrastructure support and collaborative partnerships.

Community Education and Awareness

UnitedHealthcare engages Kansas communities through the delivery of community-based educational interventions. Our community education strategy ranges from speaking at events and hosting booths at health fairs to targeted, evidence-based training programs. By connecting with and educating the community, we can jointly provide action to address Members' whole-person needs.

UnitedHealthcare hosts or participates in hundreds of events annually to promote health and wellness in collaboration with faith communities, schools and CBOs (e.g., back-to-school fairs, community baby showers). Since 2019, **we have attended 1,184 events and provided in-person health and wellness information to 130,369** individuals in Kansas communities. In addition, community partners look to our subject matter experts for evidence-based recovery and resiliency trainings. Since 2019, we have hosted over 100 recovery and resiliency classes (e.g., mental health first aid [MHFA], Seeking Safety and Question, Persuade and Refer [QPR]) throughout Kansas in both English and Spanish and reached over 1,000 participants. These programs promote awareness and understanding of BH needs, a crucial component of supporting Members in managing their overall health and addressing any co-occurring disorders.

- **MHFA:** Educates community members to recognize and respond to mental illnesses and SUD, equipping them with the necessary skills to assist and support individuals who may be developing a BH or substance use concern or experiencing a mental health crisis. We provided grants in the amount of $100,000 and $75,000 to the Association of Community Mental Health Centers and to Horizons Mental Health Center, respectively, to provide MHFA trainings to our communities.

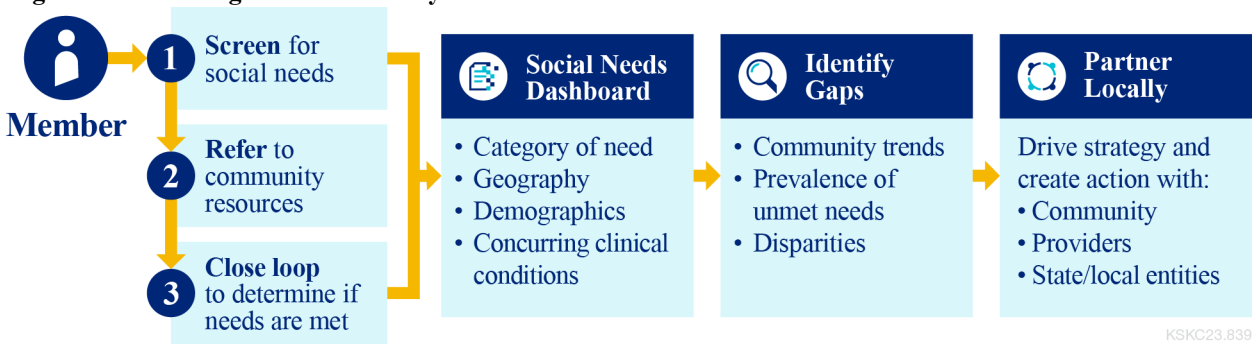
- **Seeking Safety:** An evidence-based, present-focused counseling model to help people attain safety from trauma or substance abuse. It is known for its relevance to vulnerable populations, including homeless, criminal justice, domestic violence, people living with HIV, severe and persistent mental illness, veterans and active-duty military. **We are the only organization nationally allowed to train peers to facilitate Seeking Safety.**
- **QPR:** Helps prevent deaths by suicide and reduce the stigma associated with mental illness. QPR teaches laypeople and health care professionals to recognize the warning signs, clues and suicidal communications of people in trouble and to act vigorously to prevent a tragedy.

Community Infrastructure Support and Collaborative Partnerships

Through our CBO partnerships in Kansas, we remove existing barriers and help build a sustainable and equitable infrastructure for access to quality care and care coordination. We designed our comprehensive approach with the community's needs and resources in mind to support community infrastructure and sustainability of efforts and partnerships. By establishing feedback loops with CBO partners, Members and other stakeholders (e.g., UnitedHealthcare staff, the Provider Advisory Committee, the Member Advisory Committee), we continually improve and adapt to changing circumstances. As we innovate across systems, bringing together the right stakeholders to address Members' needs holistically, the voice of the Member informs improved, measurable and sustainable outcomes.

Our UnitedHealthcare teams use the Findhelp SDOH referral platform when they identify SDOH needs. This platform offers a large registry of CBOs and confirms the outcome of every service referral to one of the entities in its network. Its closed-loop tracking capabilities and its data and analytics functions allow our teams to monitor the referral completion.

Figure 9-4. Working with Community Partners to Address SDOH Needs



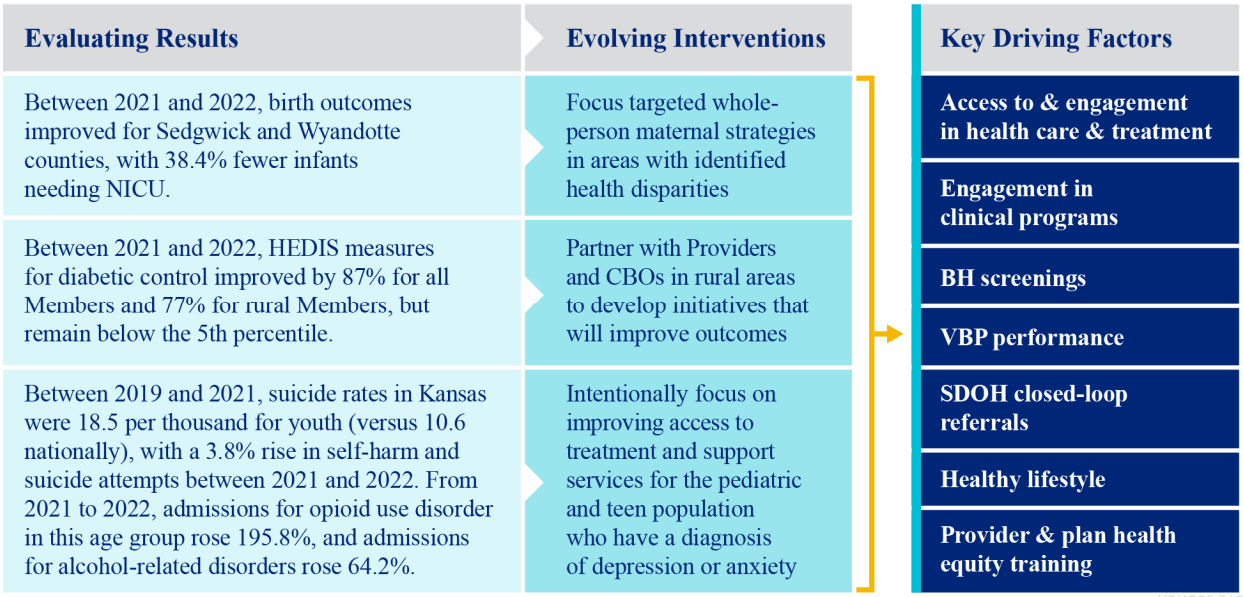
Since the beginning of KanCare, we have supported community initiatives that promote integrated, whole-person care, especially in frontier and other medically underserved areas. An example of this support is our investment in Project ECHO (Extension for Community Healthcare Outcomes). We partnered with the University of Kansas to identify, develop and implement school-based BH strategies. Our $350,000 investment allowed them to expand their emphasis on serving rural and frontier communities in Kansas. The Project ECHO training sessions for clinical partners will address critical needs in the domains of lead testing, prescribing psychotropic medications to older adults and health care equity.

Measuring, Monitoring and Evaluating Our Strategies

Advancing integrated, whole-person care involves a multifaceted monitoring and evaluation approach. We use State-required and prevalent industry best practices based on CQI science for

evaluating our integrated, whole-person care strategies, including HEDIS, NCQA PHM Evaluations, Health Equity Accreditation Evaluations, and Quality Assurance and Performance Improvement Plan (QAPI) Program Evaluation. We go beyond industry standards by developing all-encompassing monitoring aligned to our Kansas PHM strategies: (1) empowering Members, (2) evolving our network and (3) engaging communities. Our monitoring provides a comprehensive view of health care quality and performance, enabling a more accurate and complete evaluation of health care service delivery. See the figure for three examples.

Figure 9-5. Measuring, Monitoring and Evaluating



Evaluating the Impact of Strategy 1

Evaluating the effectiveness of our whole-person care efforts is ongoing and involves frequent monitoring, analysis and adjustments. We design our evaluations to confirm programs and interventions operate as intended, reach the targeted population and achieve desired clinical, quality, utilization and experience outcomes. We use a variety of data analytic tools to monitor changes in Member health outcomes and program engagement and respond promptly. For example, our Population Insights (Pop-I) tool enhances our understanding of Member utilization, population needs and disparities, and our Medical Operations Dashboard offers more than 70 reports with indicators that help manage daily clinical operations.

From 2021 to 2022, Members enrolled in high- and moderate-risk care coordination experienced the following improved health outcomes after program enrollment:

- A 3.0% decrease in inpatient admissions per thousand, 5.7% decrease in ED visits per thousand, and 12.4% increase in physician visits per thousand
- A 20.6% improvement in diabetes blood pressure <140/90 mm Hg
- An 87% improvement in pharmacotherapy management of COPD exacerbation

These results are indicative of the support our care coordination teams provided in empowering Members, connecting them to PCPs and encouraging greater participation in their care. In addition, from 2022 to 2023, we increased the percent of Members we successfully enrolled in our Healthy First Steps maternity care coordination program by 19.0% — from 69.9% of those

Members reached to 83.2%. These improvements are a result of improved risk stratification and Member segmentation processes and additional care coordinator training on engaging and working with Members.

Evaluating the Impact of Strategy 2

Through our QAPI program, we consistently monitor and evaluate the success of our efforts to evolve the care delivery system and advance delivery of integrated, whole-person care. Our QAPI program employs data-driven, CQI processes, including benchmarking, establishing performance targets and developing cross-functional improvement initiatives when we do not meet our goals. Through this program, we monitor key performance indicators, such as:

- Member physical and BH health outcomes – e.g., Providers in our BH Outpatient Shared Savings Program for the contract period of 2022 – 2023 are seeing 7% improvement in 7-day follow-up after hospitalization (FUH) and 8% improvement in 30-day FUH compared to their baselines.
- Member satisfaction results, which reflect the quality of integrated care provided – e.g., in 2023, 89.39% of respondents to our Adult CAHPS® survey said their personal doctor was usually or always informed and up to date about care received from other doctors or health Providers. This exceeds the national Medicaid 90th percentile rate of 89%.
- Progression of Provider practices along the VBP contracting continuum – e.g., from 2016 to 2022, our Kansas VBP footprint increased from 23 Providers to over 110 in CP-PCPi.

Evaluating the Impact of Strategy 3

Our comprehensive approach to measuring, monitoring and evaluating the impact of our community efforts leverages data gathered from multiple sources to identify and categorize needs, connecting individuals with resources and fostering cross-system collaboration. Our SDOH Data Registry is an all-encompassing platform that compiles internal and external SDOH data, tracking identified social needs and their resolution at the individual and community level. Our local teams engage directly with Members, Providers and community members to understand the local health context and promote a collective impact. Examples of our community engagement monitoring and evaluation include:

- Through October 2023, we screened over 22,000 KanCare Members for social needs, referring all who wanted assistance. We closed the loop on 86% of Members and found that 85% had their needs met.
- In 2023, 15% of adults who had a crisis claim suffer from housing insecurity. To help prevent future crisis situations, we obtained Member-specific demographics and are in the process of outreaching to affected Members to connect them to housing navigator support.
- Results of our UnitedHealthcare Catalyst™ partnership with Samuel Rodgers Health Center and a CBO, Northland HealthCare Access, focuses on improving maternal and infant health by providing perinatal case management and addressing SDOH. Initial results have been significant — 30% increase in BH and dental care for obstetrician (OB) patients and 90% improvement in patients attending postpartum care appointments for mother and baby.

Our efforts to advance integrated, whole-person care are truly organization-wide. We engage key stakeholders in developing innovative strategies, and we measure our initiatives and outcomes so that we can strategically invest our time and Kansas' investment in us to support population health advancement in our state.

Integrated, Whole-Person Care

10. Describe the bidder's methods to identify, track, and address the social needs that impact Members' health Social Determinants of Health (SDOH) for its KanCare Members, for Members in Care Coordination, and those who are not. Include the following in the bidder's response:

UnitedHealthcare's Dedication to Address SDOH

Meeting Medicaid eligibility requirements inherently puts our Members among the most vulnerable in our communities. Limited income, coupled with unmet social needs for basic living essentials like food and stable housing, can significantly impede one's ability to care for their physical and mental health. To relieve the impact of unmet social needs on health, well-being and disparities, we weave SDOH support into all that we do.

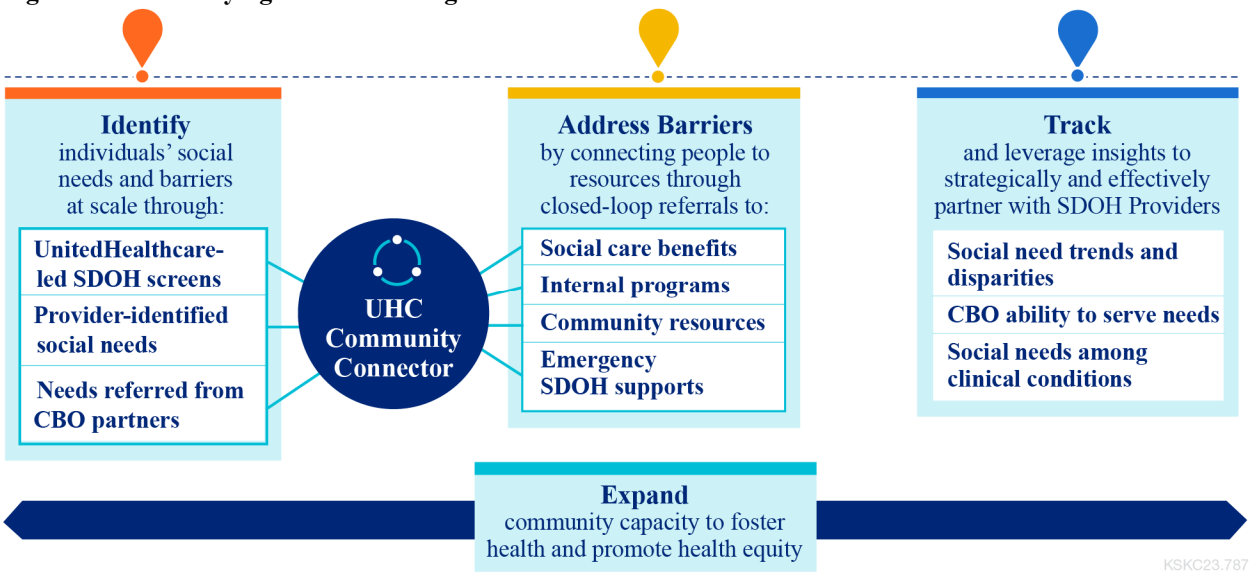
Experience Identifying and Addressing SDOH Needs

In 2023, we **screened over 15,500 KanCare Members** for social needs, referring all who wanted assistance. We closed the loop on 81% of referrals and found that **80% had their needs met.**

We identify, address and track our Members' SDOH needs holistically, support communities cooperatively and promote health equitably by establishing meaningful relationships with Providers and local CBOs. We embed SDOH screening into all Member touchpoints, including those in care coordination, to identify needs, provide closed-loop referrals and track their success. While we deploy multiple tools to address needs at scale, we have designed our process to feel seamless, enabling us to deliver empathetic and tailored support. Our consideration of the Member experience and the impact unmet social needs have on health underscores our commitment to whole-person care.

We screen for social needs across all five SDOH domains, with the most prevalent needs being food security, employment and housing, which account for 36%, 34% and 22% of social needs, respectively. In 2019, we hired specialized, Kansas-based professionals with expertise in these domain areas. We apply insights from our tracking of needs and their resolution to drive our strategic partnerships with SDOH resource Providers. Our investments in SDOH supports aim to amplify their capacities, thus empowering our Members to lead healthier lives.

Figure 10-1. Identifying and Addressing Social Needs



a. The methods, strategies, and tools the bidder will use to identify and track KanCare.

Identifying KanCare Members' Social Needs

Identifying social needs is the first step in addressing them. Our strategy is to leverage each Member touchpoint as an opportunity for SDOH screening, incentivize SDOH screening and share social needs data with Providers and develop partnerships with CBOs who make referrals to our teams for individuals we jointly serve. To make these engagements most impactful, we use a range of tools and trainings, which are particularly helpful for those who do not specialize in SDOH but who still offer support, such as our member services team. **One hundred percent of our member service advocates serving Kansas have completed SDOH training.** When Members have a need, and want our assistance addressing it, we provide closed-loop referrals to resources. With a closed loop with needs met rate of 80%, our teams have demonstrated their effectiveness to address KanCare Member social needs. The following table summarizes our social needs identification strategy, regardless of the Member's participation in care coordination.

Foundational Practice: Honoring Preferred Language

Because language barriers can hide unmet needs and lead to inequities, we remove these barriers by offering:

- Bilingual staff
- Translation of assessments and applications into multiple languages
- Oral interpretation services for all Member contacts with UnitedHealthcare
- Oral interpretation to Providers for use during medical appointments

Methods and Tools Used to Identify Members' Social Needs	
Methods to Identify SDOH Needs	**Member Assessments include SDOH Questions** – Examples include HST, health risk assessment, maternal initial risk evaluation
	Member Services SDOH Screening – System-prompted, proactive SDOH screening and referral offered on all inbound calls
	Incentivize Provider-Submitted Z Codes – Ingest applicable Z codes into our SDOH Registry and pay Provider incentives for submission of these codes
	Data Sharing with Epic – Seamlessly ingest Provider-identified needs from Epic; will seek to expand to other EMR systems
	CBO Referrals to UnitedHealthcare – Identify needs for those we jointly serve and coordinate to make sure they receive full scope of available benefits
Tools to Improve Engagement	**SDOH Staff Training** – Increases SDOH awareness and how to address them
	Empathy Training – Improves empathetic conversations to foster trust
	Protocol for Responding to and Assessing Patients Assets, Risks and Experiences (PRAPARE) Questions – Uses evidence-based tools as our basis
	Provider Training on Screening and Coding – Promotes adoption

Because it is our mission to help individuals live healthier lives and make the health care system work better for everyone, and in alignment with requirements of **Scope of Services 7.4.B.13**, our approach to understanding our Members' social needs applies to every Member, regardless of whether they are in care coordination. If, through this process, we learn that a Member has more complex SDOH needs, we can also trigger enrollment in care coordination for longitudinal

support, consistent with **Scope of Services 7.4.1.D.19**. Given that Members in care coordination have complex health and social needs, we administer more detailed assessments and provide additional documentation in their care plans.

Tracking KanCare Members' Social Needs

The way we identify an SDOH need determines the system in which the data is stored. For instance, member service advocates document everything in an integrated service desktop solution, Maestro. Our IDT uses CommunityCare, our clinical IT platform, while Providers use their electronic medical records. To unify these systems, we have developed an SDOH Registry that routinely draws from various data sources, serving as a consolidated SDOH data repository. After processing and quality assurance, this registry becomes a rich source of Member and community insights. **With our average annual screening of over 5 million individuals, including over 52,000 individuals in Kansas across all insurance types, UnitedHealthcare houses one of the country's most comprehensive SDOH datasets.** This data enables us to identify needs and devise strategies to address them at individual and community levels. While our SDOH Registry forms our back-end infrastructure, Member-level information is accessible through our integrated SDOH referral tool, UHC Community Connector.

b. The individuals (e.g., MCO Care Coordination staff, care coordinators in other Care Coordination models) responsible for following up on identified SDOH needs, and the process for connecting KanCare Members to available resources.

Individuals Responsible for Following Up on Identified SDOH Needs

While getting connected to resources to satisfy unmet social needs is critical, it is often who connects you to those supports and how they made you feel that makes a lasting impact. To make sure our Members are understood and supported, especially with their most essential needs, we bolster our IDT with highly specialized, Kansas-based SDOH staff who implement tailored strategies that align with the SDOH needs most reported by KanCare Members. In the following table, we describe the roles of those responsible for following up on identified SDOH needs.

Role and Description of Supports	
Roles That Support All KanCare Members	
Member Service Advocates	At the end of inbound calls, advocates offer additional support, conduct an SDOH screen and, if needs are identified and the Member wants assistance, use UHC Community Connector to connect the Member with resources.
SDOH Navigators	Specially trained member service advocates who can make outbound calls. In Kansas, these navigators support individuals with failed closed loops, helping the individuals connect to resources until their social need is met.
Kansas-Based Interdisciplinary Team Roles That Support All KanCare Members	
Housing Navigator	Assesses Members' housing needs, identifies barriers affecting housing stability, helps develop a housing plan and navigates Members to resources. Manages housing programs and trains staff and community partners.
Food Access Specialist	Works on nutrition education strategies, provides training and education for our health service team, and works with clinical and community partners for food-access-related strategies. Manages our internal food access programs.
Employment and	Develops expertise on which employment-based supports exist and how to effectively use them for our Members. Manages the education value-added

Role and Description of Supports	
Education Specialist	benefit of $200 for education support and directly supports Members seeking employment or looking to increase income through upskilling.
Kansas-Based Interdisciplinary Team Roles That Support Those in Care Coordination	
Community Health Workers	CHWs engage Members to complete a needs assessment and develop a personalized care plan. For social needs, CHWs collaborate with local partners to secure resources and coach Members to promote self-management. We also coordinate with Community Health Representatives and Promotoras to provide health education with cultural sensitivity to American Indian and Hispanic Members.
Care Coordinators	Work with at-risk Members to develop individualized care plans, including to address social needs. If a Member faces complex social needs, our care coordinators engage specialized SDOH leads as appropriate.
Peer Support Specialists	These unique members of the care team apply their experience with SUD or BH conditions to engage Members in care, including to help them remove SDOH barriers.

Process for Connecting KanCare Members to Available Resources

Once we learn a Member has an identified SDOH need, we determine whether they want our assistance and navigate to available resources. Our strategy is to link Members to supports that optimize their available benefits without depleting community resources. Our ideal order of supports begins with connecting Members to additional benefits they could be eligible for, then relevant internal programming and value-added benefits, and finally, local CBO-provided supports. As part of our commitment to SDOH needs, we offer special programs for urgent needs such as food delivery and housing stability, where appropriate. Generally, the process for connecting Members to available resources will follow one of two paths: supports offered by UnitedHealthcare or those offered externally, like additional benefits or by CBOs.

Connecting Members to External Support: Benefits and Community Resources

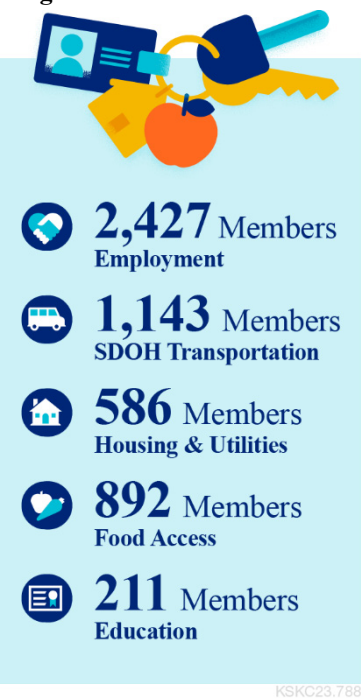
Upon identifying an SDOH need, our systems seamlessly integrate with UHC Community Connector to locate appropriate resources. When an SDOH need is selected in UHC Community Connector, it displays a range of resources, from relevant benefits such as the Supplemental Nutrition Assistance Program or the Federal Lifeline program, to resources local to the Member's ZIP code. If a Member expresses interest, we can facilitate a warm transfer to support. All identified SDOH needs and referrals are recorded in our SDOH Registry for tracking and analysis. After 30 days, an automated telephonic outreach checks if the Member's needs have been met. If not, an SDOH navigator provides additional support until their need is resolved. With UHC Community Connector, powered by Findhelp, we can typically find relevant community resources in Kansas, including 787 food programs, 627 housing programs and 407 vocational programs, among others, to support our Members' needs.

Process to Connect Members to UnitedHealthcare Programming

We supplement existing community resources with our internally funded SDOH supports. The provision of direct SDOH supports is a key aspect of our ability to have strong outcomes for meeting Members' needs; among Members with closed-loop referrals, four out of five of our

KanCare Members have their needs met. Upon identifying that a Member has an unmet social need through assessment that would be appropriately served using internal programming, our member service advocate or care coordinator educates and refers them to one of the following offerings:

Figure 10-2. Members Served through Internal SDOH Programs 2021 – 2023



- **Employment and education support:** Obtaining education, in-demand job skills and gainful employment can not only feel daunting but be costly. If our education and employment specialist is unable to connect Members to support in the community, they are empowered to provide adult Members with up to $200 for education support, such as GED classes, coding classes, resume writing workshops and English as a second language classes.
- **Transportation for SDOH:** Since transportation is critical for access to social supports, we provide up to 24 round trips per year for nonmedical transportation. Destinations include grocery stores, food pantries and libraries.
- **Housing stabilization funds:** Our Housing Stabilization Funds program have provided assistance for eligible Members experiencing homelessness or who faced risk of becoming homeless to obtain and or maintain housing. We will align these funds to meet new In Lieu of Service requirements in 2024. By enabling our team to support Members' housing needs flexibly, we empower them to remove barriers that would otherwise risk our Members' safety and well-being.
- **Food access – medically tailored meals post-discharge:** To combat food barriers and help prevent readmissions when Members return home from a hospital, skilled nursing facility or rehab facility, we give 14 nutritious meals prepared by chefs and registered dietitians. We can tailor these meals to meet cultural needs as needed.
- **Food access – pregnant Members and new mothers:** Members who have a high-risk pregnancy and are engaged in care coordination will receive $145 in healthy food support per month in the last trimester and first month postpartum.
- **Food access – medically tailored meals for acute cases:** During especially precarious times (e.g., recently housed after being homeless, transitioning back from incarceration), we remove food access and preparation as a barrier to stability. Our standard offering is one week of meals; however, our care coordination teams have flexibility to request extensions.

c. The bidder's approach to making SDOH resource information available to its staff and Providers responsible for addressing Members' SDOH needs.

Making SDOH Resource Information Available to Staff and Providers

While an array of resources exists to help address unmet social needs, maintaining awareness of their existence and how to navigate them can be challenging, especially for those whose focus is clinical rather than on social supports. To streamline awareness of resources, we take the following approach, outlined in more detail in the following table:

- Develop and use tools that summarize available resources
- Designate a staff member as the lead or expert for a tool and resource area

- Communicate routinely to disseminate knowledge

In addition, we empower our Members by embedding UHC Community Connector directly into our Member portal, enabling them to identify and self-refer to available resources.

Approach to Making SDOH Resource Information Available to Staff and Providers			
Tools That Summarize Available Resources		**Staff**	**Providers**
Findhelp	Findhelp is our main tool to make SDOH resources information available via UHC Community Connector. It is also available as a free tool for Providers.	✓	✓
Integrated Referral Intake System (IRIS)	Given its family focus, IRIS is used primarily to link relevant Members to maternal and child services.	✓	✓
SDOH Resources and Value-Added Benefits Guide	To raise awareness of SDOH resources, we created a two-page summary of our internal programs and how to access them. It serves as a comprehensive guide, creating awareness and promoting uptake.	✓	✓
SDOH Domain Job Aids	Available by SDOH topic, these include tips like how to effectively search and key resources by geography.	✓	
Designated Staff as the Lead or Expert		**Staff**	**Providers**
Dedicated Staff for Social Domains	As part of the integrated care team, specialized roles for food, housing, employment and education share their knowledge with peers and Providers	✓	✓
Intersectional Teams	We create cross-functional teams to disseminate information on tailored support for subpopulations. For example, our justice-involved team taps CHWs, the housing navigator and the employment and education specialist, who together share social support resources uniquely available to this population.	✓	
IRIS Champion	A registered nurse on the maternity team serves as the expert on the tool, fostering IRIS adoption and proficiency. Their understanding of the tool's functions enables them to train others, troubleshoot issues and provide relevant insights.	✓	
National Findhelp Lead	Given the importance of Findhelp to consolidate available resources, a national team lead trained on the unique needs of Kansas serves as the Findhelp champion, providing cross-team teachings to enhance the tool and how we use it to serve our Members.	✓	
Routine Communication to Disseminate Knowledge		**Staff**	**Providers**
Referral Platform Training	All Member-facing staff are trained on Findhelp and UHC Community Connector through live trainings, on-demand training and monthly office hours to make sure staff stay aware of available social supports.	✓	

Approach to Making SDOH Resource Information Available to Staff and Providers			
Quarterly SDOH Presentations	Presentations emphasize the importance of assessing and identifying SDOH-related issues early to avoid catastrophic events and reinforce knowledge of SDOH resources and programs. All Kansas staff participate.	✓	
SDOH Data in Point of Care Assist® (POCA)	Integrates Member health and social data into Providers' EMR. A flag in POCA notifies the Provider of any identified Member SDOH and the date this need was identified. We will continue to develop POCA to include suggested next steps.		✓
Bidirectional SDOH Data Sharing with Epic	For Providers who use Epic, data sharing directly with their EMR allows us to have visibility on SDOH insights through systems they already use, seamlessly increasing visibility to Members' needs.	✓	✓

d. The methods and tools the bidder will use to track Member access to necessary resources (e.g., geographic information system [GIS], "closed loop referral" platform).

Methods and Tools to Track Member Access to SDOH

Connecting our Members to resources does not necessarily mean they access them, so we track our SDOH referrals to not only close the loop but confirm that the underlying need has been met. While industry standards consider a loop closed when feedback is received from the resource a person was referred to, our approach is more comprehensive. We supplement CBO-provided loop closure with automatic Member-level outreach, striving to directly understand whether we are meeting our Members' needs. We take this endeavor seriously, using multiple tools that, when taken together, will highlight whether a gap exists between a need and the resources available in the community to meet that need. If a discrepancy exists, we can adjust our internal value-added benefit offerings and inform community partners so we can work together to build and expand capacity.

Driving Tool Adoption

We have achieved success in making referrals and meeting Members' SDOH needs because we invest in tools that make it easier for our team to address social needs. After embedding UHC Community Connector within our care management platform, **referrals made to KanCare Members increased 15% compared to the year before integration.**

Methods and Tools Used to Track Member Access to Necessary Resources	
Method	
To verify we have the most comprehensive view of Members' access to necessary resources, we use a range of tools, including closed-loop referral platforms and geographic information systems, that together track individual access to SDOH supports and community-level access, positioning us to make relevant insights to support our Members and Kansas' communities.	
Tools to Track Access to SDOH Supports	
UHC Community Connector	We have developed a versatile tool that integrates with leading SDOH referral platforms and our internal systems, making it easier for our teams to view the information within their workflow, regardless of the platform the information comes from. It facilitates effortless data connection with CBOs. Currently, the tool operates using Findhelp in Kansas. Its integration with our systems

Methods and Tools Used to Track Member Access to Necessary Resources	
	allows for interchangeability between platforms, without disruptions to our users. This means we can switch platforms (e.g., to Unite Us), if deemed more suitable, without any inconvenience to our users.
Closed-Loop Referral Engines	**Findhelp.** A comprehensive, nationwide online social care platform that connects users with free or low-cost social services. As the most expansive network among referral platforms, with over 5,000 listings in Kansas, Findhelp enables both the referrer and the recipient to close the loop, enabling accountability and efficiency. Our maternal team uses a Provider-led bidirectional platform for maternity and family services created by the Kansas University called **IRIS.** We have used IRIS in Sedgwick and in the Kansas City Metro area since 2020 and plan to expand our use to new areas based on SDOH needs, and whether IRIS has resources to meet those needs in geographies outside the Kansas City metro area.
Automatic Telephonic Outreach	While CBOs can close the loop on referrals, they receive through Findhelp and IRIS, we supplement this with information provided by our Members directly. Once a referral is documented in UHC Community Connector, it automatically launches a phone call to the Member to assess whether the referral met their need or whether they need additional assistance.
Member SDOH Insights Dashboard	The dashboard tracks the number of SDOH screens that occurred, needs identified, referrals made and needs met. Needs are categorized into domains (e.g., food, transportation), and data can be stratified by geography, race, ethnicity, language and other factors to tailor hyper-local interventions.
CBO Insights Dashboard	This dashboard offers comprehensive summaries of our SDOH referrals. It displays the count of referrals to each CBO, categorized by SDOH domain and location, and shows the referral success rate. In addition, it provides data on Member satisfaction with the CBO, where available.
SDOH Clinical Dashboard	Our SDOH clinical dashboard shows the intersection of 53 clinical diagnoses, our Members' SDOH indicators and key demographics, which enables us to consider social needs when designing clinical initiatives and policy advocacy.

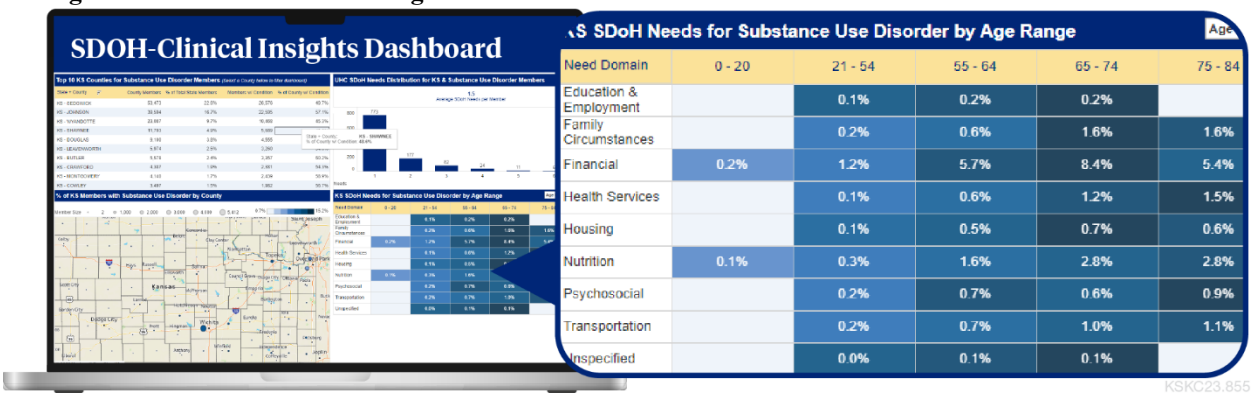
As a standalone, each tool contributes a data element or insight on Member access to necessary social supports. For example, our closed-loop referral engines allow the referred entity to report on whether the Member referred to their organization ultimately accessed their services. Our automatic telephonic outreach to the Member supplements this closed-loop data with the Member's account of whether they accessed their referred support, whether they no longer need support, or if they would like more assistance with resolving their need(s). These tools are critical to tracking access on a Member level.

Because social needs often result in system-level barriers, we are committed to tracking access at a population level. Together, the Member and CBO insights dashboards highlight the degree to which our Members successfully access the supports they need, allowing us to visualize differences in SDOH needs, referrals, loops closed and needs met by geography, language, race or ethnicity, age and gender so we can identify potential disparities. While the top social needs among KanCare Members are food, housing and education and employment, their order of

prevalence varies by county. Similarly, our rate of meeting Members needs also varies by counties, with rural and frontier counties having a lower rate of needs met than urban centers which have access to a greater volume of CBOs. Sedgwick, for example has a need met rate of 84%, whereas Barton's rate falls to 75%. By gaining insights into this data, we have been able to tailor our programming to increase the likelihood that Members will have their needs met, regardless of geography.

The following figure provides an example of our SDOH Clinical Insights Dashboard and the intersection of social needs among individuals with SUD, underscoring the prevalence of financial pressures, particularly among adults older than 55. While age and life stage can drive differences in prevalence of SDOH needs, we have found other factors like geography, race and ethnicity can also drive disparities. For example, though the sample size is low, our needs met rate among Hispanic Members is 55% compared to 84% of non-Hispanic white Members. This underscores the need to leverage culturally and linguistically appropriate connections to support and strengthen our partnerships with community Promotoras, such as El Centro Inc., to better engage and support our Hispanic Members.

Figure 10-3. SDOH Clinical Insights Dashboard



We use geographic information systems, not only for monitoring social needs but also for tracking Member impact during natural disasters and weather events. Recognizing that environmental hazards disproportionately affect vulnerable communities, we have developed a responsive alert system, consistent with requirements in **Scope of Services 7.4.1.C.22.** This system triggers when a Member who requires uninterrupted services is potentially affected by an environmental hazard. For example, if adverse weather forces a power outage affecting an individual on a respirator, our system alerts the IDT. This triggers a disaster flag outreach, prompting the care coordinator to liaise with our housing navigator, making sure temporary shelter is secured until electricity is restored. This proactive approach allows us to support our most vulnerable Members effectively during crises.

e. The bidder's efforts to engage, collaborate with, and support SDOH resource Providers.

How We Engage, Collaborate and Support SDOH Providers

We are leaders in not only collaborating but convening partners. We amplify community-based efforts to improve Members' health outcomes. Our staff volunteer for thousands of hours per year in local communities for the SDOH Providers with which we refer and collaborate.

Engaging and Collaborating for Community-Led Change: UnitedHealthcare Catalyst™:

UnitedHealthcare recognizes the unique impact to convene cross-sector community partners. One example of how we support these efforts is through UnitedHealthcare Catalyst, a distinctive community integration model that convenes a formal collaboration of health care and community partners to address health disparities and align and expand community capacity to improve health outcomes. To reduce disparities, Catalyst combines detailed community health data analysis and community voices to address the highest-priority health challenges. Our UnitedHealthcare Catalyst partnership with **Samuel Rodgers Health Center and a CBO, Northland HealthCare Access**, focuses on improving maternal and infant health by providing perinatal case management and addressing SDOH. The initial results for Members in this Catalyst partnership have been significant:

- A 30% increase in BH and dental care for OB patients
- A 3.2% improvement in full-term births
- A 90% improvement in patients attending postpartum care appointments for mother and baby

We commit to convening key community leaders in Kansas to expand evidence-based community-led solutions like our experience with Samuel Rodgers to meet Kansas' needs.

Support to Expand Capacity for SDOH Resource Providers

Our local SDOH team works with CBOs across the State to refer applicable supports and services to SDOH service Providers. Although there is a broad range of service Providers listed in Findhelp, our SDOH team has **engaged** the primary points of contact in the leading organizations that represent each Kansas region to develop a rapport and learn the local nuances. Our SDOH team **collaborates** with CBO staff to track availability of services for common SDOH needs in each area. For example, our housing navigator maintains communication to track openings in affordable and accessible housing by geographic area to support the care management process. In addition, we facilitated process improvement discussions with stakeholders such as food pantries to address root causes of Member food insecurity. In Southeast Kansas, to address a regional gap identified in food access, we convened key stakeholders, including grocery store managers and school administrators, to develop creative solutions to address community food insecurity.

> "UnitedHealthcare was instrumental in assisting us at the start of the COVID-19 pandemic. We were able to focus part of the funding on food boxes to be distributed through mobile food pantry settings. This allowed us to safely support our neighbors during a high peak in demand for services."
>
> *– Brian Walker, President & CEO, Kansas Food Bank*

To **support** and increase the capacity and impact of existing community supports for SDOH needs, we have deployed Empowering Health grants to expand community capacity to provide the following social supports impact in Kansas:

- **American Heart Association:** Our $275,000 donation (2023 – 2024) contributed toward a partnership with the four Kansas tribes via food access and nutrition efforts.
- **Kansas Department of Health and Environment (KDHE) Nutrition Programming:** Our $175,000 donation (2021 – 2023) helped KDHE reach 3,105 people. KDHE uses local partnerships to address SDOH in the Wichita community, delivering health education, food

access and nutrition programming in the Evergreen and Fairmount neighborhoods and among the refugee and LGBTQ+ communities.

- **Kansas Food Bank Warehouse, Inc.:** Our $30,000 donation (2021 – 2022) supported 24,985 people and purchased 854,976 meals distributed to students who struggle with emotional and behavioral regulation.

New 2024 Investments in Kansas SDOH Resources

- Communities Organizing to Promote Equity: $80,000
- Kansas Statewide Homeless Coalition: $50,000
- Workforce Centers: $50,000
- LiveWell Finney County: $50,000
- Kansas Birth Justice Society: $30,000

We use the scope of UnitedHealthcare resources to expand national programs with demonstrated impact. To combat declining economic opportunity that reduces economic vitality and results in chronic stress, we focus on upstream assistance. A three-year partnership with Goodwill Industries International allows us to support the expansion of their **Opportunity Accelerator** program nationwide, including the neighboring location of Kansas City, Missouri. This initiative offers end-to-end job placement support. We will partner with employers to co-design job-specific curricula, connecting newly skilled talent with opportunities. The model features closed-loop referral and measurement to track outcomes for individuals and community infrastructure.

Our **Housing+Health** strategy works to bring the functional components of the housing and health care systems closer together. Our approach has evolved from focusing on a small subset of Members experiencing homelessness to more broadly supporting those at risk for housing instability. Our initial Housing+Health high-acuity pilot supported 25 individuals and resulted in a perceived stabilization in appropriate health care engagement. Comparing claims 12 months pre- and post-entering the program, we found a decrease in claims for inpatient and emergency room services, and a simultaneous increase in claims for outpatient services. Although 60% of those who began program successfully transitioned to permanent housing the limited scalability of the pilot has led us to pursue housing capacity grants as an alternative approach to supporting housing. Communities often lack the resources to comprehensively address housing-related needs, and housing organizations report lack of adequate staffing and resources. Housing partners will use these funds to assist individuals' successful transition to sustained tenancy with housing-related services such as application fees, security deposits and utility arrears. We establish bidirectional data-sharing agreements to evaluate the effect of our partnership to identify opportunities for systems improvement.

Lastly, we are growing our efforts related to environmental justice, recognizing the intersecting impact that poverty, social structures and the environment has on health. For example, many of our low-income families reside in areas of elevated air pollution caused by proximity to major roadways and industries. In 2022, we partnered with the Wyandotte Health Equity Task Force and paid for the materials to build clean air boxes, built by local high schools and distributed in community. During this summer's extreme heat wave, we funded local water distribution. We will continue to evaluate and build on investments for areas of support that are important for our Members and our communities.

Transformative Commitment for KanCare

Each year, we will provide two Kansas housing services organizations with $15,000 to expand their capabilities and reach.

Integrated, Whole-Person Care

11. Describe the bidder's approach to identifying and addressing health disparities for KanCare Members. Include the following in the bidder's response:

Approach to Identifying and Addressing Health Disparities

At UnitedHealthcare, reducing disparities between populations is a core element of how we define and implement our population health strategy to improve the health and well-being of our Members and advance integrated whole-person care. We leverage a data-driven approach to proactively identify and address health disparities and protect against implicit bias. We collaborate with local stakeholders to support changes needed to address Kansas health disparities-based data and alignment with KDHE priorities. Our comprehensive approach supports a measurable impact on Kansas health disparities in these three pillars:

- Implementing a health equity framework, grounded in Kansas population health experience, to identify and address disparities
- Preempting and monitoring for potential unintended bias that, without intervention, could lead to disparate provision of care and outcomes
- Using our six-step population health process for CQI to meet or exceed our disparity reduction goals

Reducing Disparities in Birth Outcomes

To address local disparities identified for Black infants requiring treatment from NICU, we increased care coordination engagement and added doula support, which led to demonstrable improvements in birth outcomes with year-over-year reductions in NICU rates:

Sedgwick County. 16.5% (2021) to 9.4% (2022)

Wyandotte County. 12.6% (2021) to 8.1% (2022)

a. The bidder's definition of health disparities.

Defining Health Disparities Within a Health Equity Framework

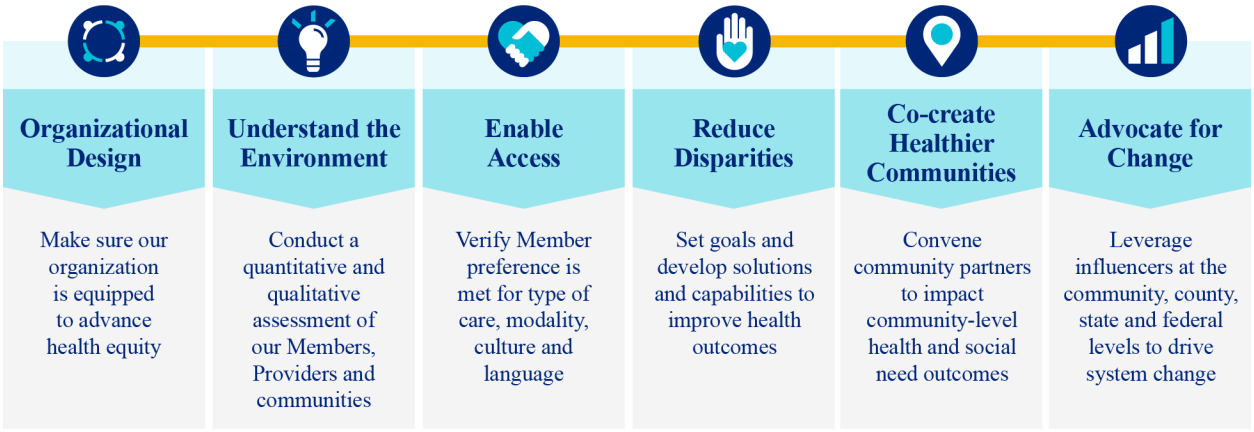
Health disparities are avoidable differences in health status among a subgroup of the population, including differences that occur by race or ethnicity, disability, sexual orientation, gender or gender identity, geography, preferred language, education or income and living environment. Society often links these disparities to social, economic and environmental disadvantages and structural inequities that affect historically marginalized communities. Health disparities encompass a higher burden of illness, injury, disability or mortality experienced by one group relative to another. To address all of these disparities, UnitedHealthcare uses targeted strategies that aim to improve the quality of life and care provided to underserved groups. Informed by the experience of 20 UnitedHealthcare affiliate plans earning Health Equity Accreditation, we have established systems and processes to evolve our understanding of health disparities and inequities that are consistent with NCQA standards. We will leverage this experience as we apply for NCQA Health Equity Accreditation in Kansas in 2024.

UnitedHealthcare Equity Framework

Identifying and addressing health disparities is one component of the broader framework we use today to promote health equity in Kansas. Our framework uses a methodical approach, as we illustrate in the following figure, considering our internal structure (e.g., hiring practices, organizational design) and the external circumstances in which we and our Members operate.

This approach guides our efforts to pinpoint and rectify disparities. Although our primary focus is implementing specific interventions to address health disparities among our Members, we also actively participate in payer-agnostic initiatives and advocacy efforts that enhance the overall health of the wider Kansas community.

Figure 11-1. Health Equity Framework



As we continue to evolve our processes and organizational design to drive improved outcomes and reduced disparities for our Members, beginning in 2024, our local health equity director will oversee our health equity framework and approach to comply with the requirements in **Scope of Services 7.5.4 and 7.17.2**. The health equity director will oversee development, implementation and evaluation of the Health Equity and Cultural Competency plan; manage the application for NCQA Health Equity Accreditation in 2024; and reinforce health equity practices to close disparities and avoid unintended bias.

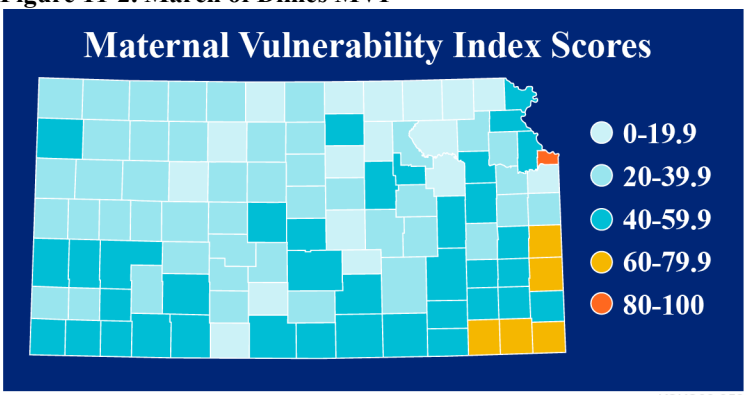
Approach to Identify Disparities

We follow industry best practices for using data and information to identify and address disparities, including the use of predictive analytics, integration of multiple data sources, use of real-time data and application of evidence-based interventions. In addition to publicly available data, we have a comprehensive suite of internally developed population health analytic tools to analyze outcomes and disparities. We supplement quantitative data with qualitative data, including feedback from Member, Provider and community advisory groups; feedback from our own care coordinators and CHWs; and analysis of State priorities. The following diverse analytic tools and sources inform our population health strategies, allowing us to identify health disparities and design initiatives that drive toward more equitable outcomes:

- **Index of Disparity (public):** We apply the index of disparity formula, a nationally used and vetted measure to assess differences among groups, to subpopulations within our membership, including by race and ethnicity, income level, education level and primary language. We use this tool to identify disparity reduction targets and action plans.
- **HEDIS® quality measure dashboard (public and internal):** In addition to using publicly available HEDIS data, we developed a customizable dashboard that analyzes Member-level detail for HEDIS measures by race and ethnicity, age, county and ZIP code. We use this information to design quality improvement projects at the population level and to address disparities for HEDIS measures within population subgroups.

- **Hotspotting and Population Insights (Pop-I) tools (internal):** We use these tools to identify risk factors, geography and demographic data, including ethnicity, diagnosis, type of utilization, cost of care and BH or substance use. Our Hotspotting and Pop-I tools enable us to view the data at both a population and individual Member level. These tools tell us where our strategies are effective for each Member and across KanCare to pinpoint opportunities to deploy new or expand current strategies.
- **SDOH dashboards (internal):** Our SDOH dashboards track SDOH data from screening through needed resolution and overlay SDOH needs with Members' clinical conditions (e.g., percentage of Members with a food insecurity and diabetes diagnosis). Data can be stratified by geography, race, ethnicity, language and other key demographics, enabling us to understand core social issues that often influence health outcomes and drive disparities.
- **Maternal dashboard (internal):** We identify Members' needs in our maternal dashboard to address health disparities across measures such as gestation age, birth weight, premature delivery and NICU admission and average length of stay.
- **Maternal Vulnerability Index (MVI) (external) scores:** We use the March of Dimes and Surgo Ventures MVI, the first county-level, national-scale tool to identify where and why pregnant Members in the U.S. are vulnerable to poor pregnancy outcomes and pregnancy-related deaths.

Figure 11-2. March of Dimes MVI



We apply these tools through our annual Comprehensive Population Health and Health Equity Assessment, a key component of our Kansas Health Equity and Cultural Competency plan. This assessment provides a 360-degree view of Kansas health outcomes, disparities, drivers of poor outcomes and systemic components such as regulator priorities and environmental challenges. We repeat the assessment annually to evaluate the success of aggregate Member, Provider and community interventions on improving health and reducing disparities. Through this assessment, we track how the health system and priorities are changing in Kansas, so we can verify strategy alignment across our suite of interventions. As a result, we set the following goals for Kansas:

Kansas Population Health SMART Goals and Equity Focus	
Aims	**Health Equity SMART Goals**
Improve or maintain strong clinical outcomes for pregnant Members and infants, decreasing the need for NICU level of care for newborns while focusing on health equity.	Achieve a 5% decrease in NICU utilization among Black newborns in Wyandotte County and all Sedgwick newborns relative to the 2021 baselines over the life of the contract.
Achieve strong outcomes for Members (including long-term services and supports Members) with hypertension, increase support for behavioral and physical health comorbidities.	Increase the controlling blood pressure measure rate in Members residing in rural areas by 25% over the life of the contract.

Health Equity Education to Preempt Unintended Bias Among UnitedHealthcare Teams

To promote health equity and preempt bias, we deploy a range of online training opportunities developed by practitioners of adult learning theory principles. We set an organizational commitment that UnitedHealthcare staff achieve at least level one in Health Equity University, our internal health equity learning platform, which requires completion of the Health Equity Foundations. The levels begin with Supporter, and the progressive sequence includes Advocate, Practitioner and Champion based on a ladder of courses. Other relevant trainings include:

UnitedHealthcare Staff Education on Health Equity, Including Unintended Bias	
Implicit Bias Training	Offered by the March of Dimes, this training helps identify implicit bias, cognitive basis that informs bias and its specific impact in maternity care settings.
Diversity, Equity, Inclusion (DEI) Series	This live series of courses delivered by external subject matter experts covers race, DEI and access and belonging.
Restorative Practices	This course teaches how to hold effective discussions by bringing together parties in a conflict to share their stories and perspective.
Trauma-Informed Practices	The training defines concepts and values of trauma-informed care and how to support health care Providers in a shift to patient-centered trauma-informed practices.
Implicit and Explicit Bias Awareness and Microaggressions	The course defines a framework for implicit bias and microaggression and offers examples of these concepts for participants to discuss to understand how people can form implicit biases and the ways they affect the lives of people who identify as Black, Indigenous and People of Color (BIPOC).
Bimonthly Health Service Staff Grand Round Sessions	We bring community speakers to share their areas of expertise to increase cultural competency (e.g., Immigration Trends and Refugee Community, Realities of Human Trafficking, Equity Made Easy, Understanding Department of Children and Families [DCF] Services).

Health Equity Education to Preempt Unintended Bias Among Providers

Driving Equity with Providers

Over two and a half years, Kansas Providers have taken **2,652 health equity-related courses on our Optum Health Education platform.**

We support Provider health equity education. We offer free, accredited, on-demand CME and continuing education units (CEU) for Providers and their staff, covering a wide variety of topics, including 25 courses on health equity. As part of our data monitoring, if we identify unintended bias among individual Providers in service delivery, our clinical practice consultants (CPCs) meet with the Providers to share the data and describe mitigation strategies to avoid the variances in the future. To preempt unintended bias in service delivery, we are working with Kansas University's Project ECHO to provide a series of educational sessions related to health equity and unintended bias for clinicians. Lastly, we prioritize the delivery of culturally aligned care by identifying Provider race, languages spoken and areas of expertise, such as LGBTQ+, in our *Provider Directory*. This approach allows our Members to select Providers who are aligned with their cultural beliefs and linguistic preferences.

b. The bidder's approach to monitoring for unintended bias in Utilization Management and service delivery in KanCare. Additionally, provide an example of an identified concern in a program similar to KanCare and the actions that were taken in response.

Monitoring for Unintended Bias and Taking Action

In health care, unintended bias includes subconscious prejudices that health care professionals may harbor and inadvertently apply when treating patients, potentially leading to disparities in service delivery, fueling disparities in health outcomes. Often influenced by factors such as race, gender, socioeconomic status or age, unintended bias can influence medical decisions, affect patient-Provider communication and contribute to health inequities. UnitedHealthcare is proactive in identifying unintended bias to reduce inequities and improve Member experience.

Our Approach to Monitoring Unintended Bias

We take steps to preempt, monitor and address potential patterns of bias within our internal teams, including utilization management (UM), and among Providers. Our approach to monitoring for any element related to equity, including bias, aligns with our overall population health six-step process, as outlined in the Figure 11-3. Establishing a consistent process creates an analytic discipline applicable to many areas.

Step 1: We begin by using data to identify priority areas. This involves reviewing literature and trends and monitor for indications of implicit bias within our data or concerns of bias directly reported by Members.

Step 2: We seek to understand the issue by applying our range of analytic capabilities to identify whether we witness a disparity that could be a result of bias (e.g., age-related bias leading to older Members not being offered certain treatments, socioeconomic bias leading to Medicaid Members receiving substandard care, racial bias leading to inadequate pain management for people of color).

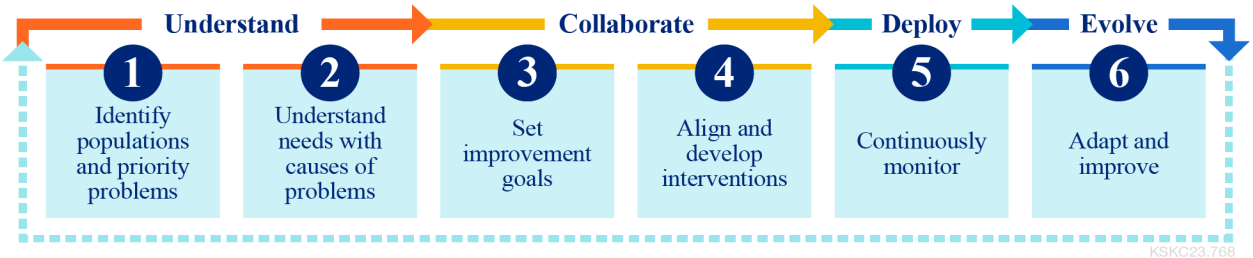
Step 3: If we encounter evidence of bias, we set improvement goals.

Step 4: We develop interventions aligned to achieve our goals.

Step 5: We deploy and continuously monitor our interventions.

Step 6: We adapt and improve our interventions as appropriate**,** applying a culture of CQI to all aspects of our care.

Figure 11-3. Six-Step Population Health Management Process



Example of Monitoring for Unintended Bias in Service Delivery: C-Sections

As documented in the Kansas Maternal Mortality Report, significant maternal health disparities exist, making maternal care a priority focus area of ours. While Black women accounted for

7.1% of births in Kansas, they accounted for twice (14%) the pregnancy-associated deaths. C-sections are associated with poorer maternal outcomes, including a higher index of death. Thus, we analyzed Member data by race to determine whether disparities in C-section rates mirror disparities in maternal mortality, suggesting bias in service delivery. While sometimes medically necessary or preferred by pregnant Members, the determination of whether to deliver by C-section is heavily influenced by the Provider and, as a result, has high susceptibility to bias. We use our Kansas-specific maternity dashboards and index of disparity analysis to monitor outcomes and detect patterns of potential bias in service delivery.

After examining C-section rates by race, including non-medically necessary C-sections, which have the highest potential for bias, we found a low index of disparity in C-section rates overall, but a high index of disparity among non-medically necessary C-sections. While this suggests a potential for implicit bias in service delivery for elective C-sections, the data is skewed, in part, due to a low sample size of births to Asian women who experienced very few (three) non-medically necessary C-sections. Nevertheless, differences in non-medically necessary C-section rates exist, with multiracial women experiencing the highest prevalence at 22.3%.

C-Section Rates by Race from July 2022 – June 2023

		C-Section Rate		Non-medically necessary C-Section Rate	
Race	**Deliveries**	**Rate**	**YoY%**	**Rate**	**YoY%**
White	2,485	30.9%	-2.7%	17.1%	-11.6%
Black	473	32.6%	2.4%	16.9%	-1.8%
Asian	43	30.2%	-11.5%	7.7%	7.7%
Multiracial	352	29.3%	5.9%	22.3%	-7.0%
Index of Disparity		**15.23**		**143.94**	

The high disparity index suggests a service delivery difference in nonessential C-sections. However, rates between white and Black Members are nearly identical, suggesting no significant evidence of implicit bias on racial grounds. Further analysis is needed to understand the slightly higher prevalence among multiracial Members, and whether Provider bias contributes. Nevertheless, this analysis showed high nonessential C-section rates exist across all racial groups, with the exception of Asian Members. Despite a year-over-year (YoY) decrease in non-medically necessary C-sections, additional efforts are needed for C-section rates to fall to fewer than 15% of deliveries, as recommended by the World Health Organization. Before moving to step four in our process to design interventions that would bring us closer to this goal, additional data is needed to better understand the circumstances leading to high non-medically necessary C-section rates in Kansas. In alignment with step two of our six-step population health process, our next action is to understand the root cause, which will involve data, discussions with Members and Providers as well as more in-depth literature reviews. From there, we will establish SMART goals, develop interventions and monitor improvement, iterating as necessary for CQI.

Example of System Improvements to Avoid Potential Bias in Utilization Management

To reduce the potential for bias among our UM team in determinations, we use InterQual® evidence-based clinical criteria and technology to promote a standard of equitable, evidence-based care. We use these criteria to apply the latest clinical guidelines to assess medical appropriateness, including updated guidelines that eliminate race-based medicine. We apply this tool by aligning with our six-step

population health process, though we rely on InterQual's team of experts and literature review for step one to identify priority issues susceptible to bias, and then we advance to steps two through six.

The application of InterQual criteria can play a significant role in reducing racial bias in clinical decision making. For example, historical creatinine equation methods gave Black individuals a larger severity threshold compared to other races, allowing for biased service delivery and potential disparity in outcomes. Both the National Kidney Foundation and the American Society of Nephrology recommended in 2021 and 2022 that labs adopt a new creatinine equation excluding race as a variable. In 2023, InterQual criteria updated to change measures for assessing kidney injury severity to ensure consistency across patients with different racial backgrounds. Specifically, when analyzing a person's creatinine level or glomerular filtration rate (GFR) as a severity marker, the InterQual system flags if old methods of calculating GFR involved serum creatinine, age, gender and race are used. This flag in InterQual raises awareness of potential racial bias if a hospital lab uses an outdated method to calculate GFR. If we identify a hospital still uses the old race-inclusive method, the medical director can intervene, adjust for this bias and encourage the hospital to update its practices. In alignment with step five of our process, we will complete an annual analysis in 2024 to evaluate the impact of the change on eliminating racial bias and identify any outlier facilities.

When changes to criteria occur, we take active measures to adopt these updates in our practice. All UM staff participate in annual trainings on InterQual updates to make sure they maintain awareness of the latest clinical guidelines. We routinely evaluate for inter-rater reliability of our UM team to help ensure application of clinical standards without bias.

c. An example of a specific health disparity in KanCare, the bidder's proposed approach to addressing the disparity, and the anticipated impact on KanCare Members.

Addressing Health Disparities for KanCare Maternal Members

We have demonstrated experience implementing our six-step process to successfully drive improvements in integrated, whole-person health outcomes within KanCare. Below we provide two examples: (1) Disparities in Birth Outcomes and (2) Disparities in Youth Suicide.

Example 1: Disparities in Birth Outcomes

Step 1 – Identify Populations and Priority Problems: Consistent with national trends, maternal and infant health disparities exist between white and BIPOC individuals in Kansas. Using our maternal dashboard, we discerned profound disparities in maternal outcomes, particularly prevalent in Sedgwick and Wyandotte counties. In 2021, the statewide NICU rates were 8.2%; however, Sedgwick County's NICU utilization was 11.3%, largely driven by disproportionate rates among Black newborns, who were admitted to the NICU at a16.5% rate. Similarly, in Wyandotte County, Black births saw a higher NICU utilization rate of 12.7%.

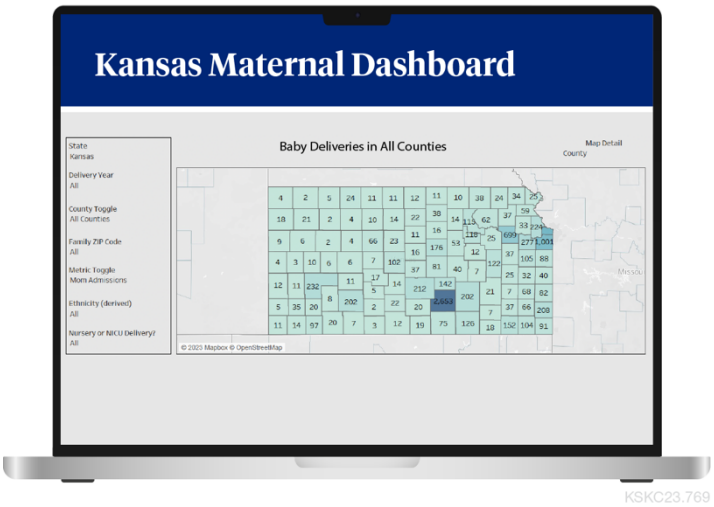
Step 2 – Understand Needs and Causes of Problems: These discrepancies stem from a complex interplay of factors contributing to racial disparities, with structural inequities and implicit bias significantly impacting the birth outcomes for Black Members.

Step 3 – Set Improvement Goals: Our team set an improvement goal to achieve a 5% decrease in NICU utilization among Black newborns in Wyandotte County and all of Sedgwick newborns relative to the 2021 baselines.

Step 4 – Align and Develop Interventions to Eliminate the Disparity: We took a flexible, comprehensive approach to increase engagement in care coordination to provide wraparound support for better birth outcomes for this vulnerable population. By using data and levering partnerships with community and Provider organizations, we implemented the following strategies to provide pregnant Members with supports during and after pregnancy:

- Expanded our maternal care coordination for all pregnant Members in Sedgwick County, regardless of their level of risk stratification
- Expanded our maternal care coordination to all Black pregnant Members in Wyandotte County, regardless of their level of risk stratification
- Implemented a Maternal CHW program in Sedgwick County for pregnant UnitedHealthcare Members, in partnership with the Center for Research for Infant Birth and Survival

Figure 11-4. Maternal Dashboard



- Expanded Universal Home visiting through Cradle KC in Wyandotte County to all community members, including UnitedHealthcare Members, in partnership with the Community Health Council of Wyandotte County
- Partnered with local doulas to provide doula care for Black pregnant Members in Wyandotte
- Conducted presentations to OB/GYN Providers and local clinics on available community supports and internal supports, including details on how to refer Members

Step 5 – Continuously Monitor: By equipping pregnant Members with the additional support of care coordination and the advocacy of a doula, we see demonstrable improvements in their birth outcomes. Initial analysis indicated uniformly strong improvements among Black births. Higher engagement in care coordination support occurred across the entire population but grew among Black Members in Sedgwick and Wyandotte, where we focused our efforts. Corresponding to higher engagement in care, we also saw decreases in NICU utilization, a strong indicator of improved birth outcomes:

Maternal Outcomes Among Black Births Pre/Post Intervention(s)				
Geography	**Utilization**	**2021**	**2022**	**Change**
Kansas	Care Coordination Engagement	15.69%	21.23%	↑
	NICU	11.07%	8.92%	↓
Sedgwick	Care Coordination Engagement	14.56%	27.58%	↑
	NICU	16.50%	9.48%	↓
Wyandotte	Care Coordination Engagement	11.11%	26.53%	↑
	NICU	12.69%	8.16%	↓

Step 6 – Adapt and Evolve: We view our birth equity efforts as collaborative and ongoing. To reduce disparities in Wyandotte and Sedgwick counties, we seek to maintain or improve strong clinical outcomes for pregnant Members and babies, decreasing the need for NICU level of care for newborns while improving health care access for pregnant Members. Based on our data analysis, we continue to monitor for potential emerging trends in maternity health disparities such as Members in the Latino community and those who live in rural counties. In addition, we expanded our doula program to include statewide doula coverage.

LETTER OF SUPPORT

"I just wanted to reach out and let you know how much I appreciate our partnership to serve families in Sedgwick County. The UnitedHealthcare maternal child CHW pilot program has truly impacted the lives of families during the challenging transition to parenthood. Since hiring two, full-time staff in March of 2022, both staff members have been certified as CHWs and attended maternal and child health trainings, including breastfeeding, safe sleep, bereavement, mental health, and postnatal warning signs. They have shared this knowledge, including how to have a healthy pregnancy and safe infant care practices with over 64 families."

– Cari Schmidt, PhD,

Director, Center for Research for Infant Birth and Survival

Example 2: Disparities in Youth Suicide

Step 1 – Identify Populations and Priority Problems: Youth mental health has become a major concern and focus as we support health and well-being of Kansans across all life stages. According to the CDC, suicide was the leading cause of death among Kansans aged 15 to 25.

Step 2 – Understand Needs and Causes of Problems: Data indicates that rural counties of Saline, Neosho, Ellis and Allen experienced a 2 to 3 times higher rate of youth suicide risk compared to Wyandotte County. To understand contributing factors, we identified lack of mental health resources in rural areas and noted that budgeting for student support services varies widely across Kansas. For example, Johnson County school districts, in the urban area of Kansas City, budget $946 per student for support services. Conversely, a frontier school district such as Greeley County budgets only $432 per student. With lower enrollments and thus lower dollars from the State, funds in many rural, smaller school districts that might have been used for student support must be redirected elsewhere. Further, of the 17 Behavioral Health Provider Incentive (BHPi) peer support Providers in Kansas, only nine are located in rural communities.

Step 3 – Set Improvement Goals: Our team set an improvement goal to achieve a 5% reduction in suicide risk among the four rural counties over the life of the contract.

Step 4 – Align and Develop Interventions to Eliminate the Disparity: In 2024, we will deploy comprehensive interventions, which will bring needed support to youth in rural communities:

- School-based mental health programs aimed at peer support for high school students
- Offer QPR training, an evidence-based intervention for suicide risk, to school professionals
- Distribute medication lock boxes aimed at reducing access to medications used in suicide and accidental poisoning for youth
- Offer MHFA training to first responders to equip them with the supports necessary to respond to mental health crises appropriately

As part of our CQI approach, once these interventions are deployed, we will continuously monitor impact (Step 5) and adapt and evolve our approach based on findings (Step 6).

Expanding BH Access in Rural Areas

We partnered with the University of Kansas on Project ECHO with an investment of $350,000 to identify, develop and implement school-based BH strategies, with an emphasis on serving rural and frontier communities in Kansas. The Project ECHO team will also develop and implement ECHO training for clinical partners that addresses critical needs related to health care equity.

Utilization Management and Services (Tab 7d)

Connecting Parents in Dodge City with Local Resources

We teamed up with Dodge City and Lactancia Latina en el Suroeste de Kansas to build a lactation bench in Chilton Park. The space includes a covered bench area for breastfeeding and signage with information in English and Spanish to connect parents to resources right in their neighborhood to support healthy starts for families.

Kansans United

United Healthcare Community Plan

Utilization Management and Services

12. Describe the bidder's strategies and approaches to ensuring appropriate utilization of services while reducing Provider administrative burdens.

Ensuring Appropriate Utilization and Reducing Provider Burden

At UnitedHealthcare, we design our utilization management (UM) programs to make sure our Members receive the right care, in the right place, at the right time. We improve the UM process by removing unnecessary administrative burden, rewarding high-performing Providers and grounding in the experience for both Members and Providers. Our strategies and approaches to support appropriate utilization of services while reducing Provider administrative burdens include:

> "The collaborative work with UnitedHealthcare is unparalleled in the KS MCO arena. We are able to work together to resolve complex patient situations. UnitedHealthcare's MCO Chief Medical Officer and Medical Director leadership, Dr. Wesley and Dr. Davis respectively, are involved with KU teams on monthly calls to discuss cases, issues and making sure everyone is on the same page. There is a clear difference in their approach in working and collaborating with the KU team to provide a higher level of care and service."
>
> *– Dr. Scott Ceule, Medical Director and Chairman of Utilization Management Committee at University of Kansas Hospital System*

- **Clear and transparent evidence-based guidelines:** We use evidence-based guidelines that provide a reliable basis for decision making and promote standardization of care, and clearly share the guidelines with Providers.
- **Simplified UM processes:** We use our unique capabilities in clinical data and analytics to make it easier for Providers to focus on caring for their patients and reduce the time spent navigating administrative processes.
- **Data-driven utilization management processes and innovative contracting:** We develop and apply innovative data-driven UM techniques and innovative contracting to help modernize, streamline and simplify the health system.
- **Experienced local staff:** We employ a diverse, interdisciplinary clinical and Provider-facing workforce who deeply understand the Kansas health care systems, regulations and Member needs and foster strong relationships with Providers.

Our UM program meets NCQA standards, reinforcing our compliance with consistent application of medical decision making in our clinical programs. **Our team scored 100% for the past two years on external audits of our process and structure supporting Utilization Management.** The objective of our UM program and supporting committees is to take the guesswork out of what is needed for medical necessity for Providers. We make our messaging clear and concise, while reinforcing internal efficiencies and reducing the unnecessary burden of the Provider to use the appeal process inappropriately.

Clear and Transparent Evidence-Based Guidelines

Our UM processes verify that Providers deliver care in accordance with evidence-based practices and acceptable care standards. The goal of prior authorization (PA) is not to limit Member access to services but rather to verify accurate clinical decision making and cost-effective, evidence-based care. We use evidence-based, nationally recognized InterQual® clinical guidelines and criteria for physical health care services; Level of Care Utilization System, Child and Adolescent Service Intensity Instrument and Early Childhood Service Intensity Instrument clinical guidelines and criteria for mental health services; and American Society of Addiction Medicine

criteria for substance use disorder. Our UM program consistently and judiciously applies standard review criteria and complies with state and federal requirements, including definitions of level of care.

Reducing Provider Burden – Transition From Milliman Care Guidelines to InterQual

Based on feedback from Providers, we implemented InterQual in 2021, which converted UnitedHealthcare physical health medical policies from Milliman Care Guidelines (MCG) to the InterQual digital framework. InterQual shortens turnaround times for clinical decisions, supports consistency and transparency and reduces administrative burden for Providers with all three KanCare MCOs having aligned clinical criteria.

To maintain a clear communication channel with Providers, we provide comprehensive, transparent guidelines that detail our operational procedures, expectations and standards. These guidelines are designed to be easy to understand and follow, eliminating any ambiguities. Our guidelines cover diverse areas such as compliance, data management and service delivery to promote a consistent high-quality Member and Provider experience. Transparency is the cornerstone of a successful partnership, and we demonstrate this by providing our guidelines openly on our Provider portal, *UHCprovider.com*. This tool aids in building a strong, harmonious relationship with Providers, ultimately leading to better services for our Members. In accordance with **Scope of Services 7.8.3**, we will directly make available the criteria we use to determine medical necessity to any Provider or Member, when requested.

Our commitment to communication continues through training and advanced notice of any changes. We provide education on our UM program, criteria and guidelines during initial and ongoing Provider training and offer numerous resources on our secure Provider portal and in our Provider manual. We notify Providers of any changes in policy at least 30 calendar days before implementation and provide clear standardized guidelines for successful determination on the first submission, which helps Providers avoid re-submission.

UnitedHealthcare's Best Practice Review Protocol

We have closely aligned our UM and Quality Assessment and Performance Improvement (QAPI) program through an integrated committee oversight structure and program policies and procedures. Our UM activities support our QAPI program by providing objective and systematic monitoring and evaluation of the medical necessity, appropriateness, efficiency, timeliness and cost effectiveness of services provided to Members. Input from our UM program provides critical evidence about health care patterns and practices. Our committee oversight translates this evidence into effective policies and procedures to enable high-quality health care. For example, using UM data analysis, our quality management and network management teams identify opportunities for Provider education and consultation through our Provider profiling program. QAPI helps Providers gain better insight into their practice patterns while identifying opportunities to improve, close gaps in care and connect Members with needed services.

Simplified Utilization Management Processes for Providers

Through our deep relationships with Providers, we hear what contributes to Provider burden directly from them. Our team uses this information to make meaningful improvements to our PA requirements and processes with a goal of reducing the Provider administrative burden and optimizing experiences for Members and Providers. We participate in committees, attend conferences and host touchpoints to obtain purposeful and practical feedback. Sources of stakeholder input include:

- Input from our Member and Provider Advisory Committees, grievances and appeals processes, Member satisfaction surveys and CEO Provider Forums
- Conferences such as Governor's Public Health Conference, Leading Age Conference, Medical Group Managers Association of Kansas, Kansas Hospital Association Convention, Interhab Conference, Association of CMHCs, and Community Care Network of Kansas
- Provider events such as Inclusion Connections, Heartstrings, Johnson County Mental Health, Catholic Charities, and National Alliance on Mental Illness
- Joint Operating Committee meetings with Provider group leadership

Leading Provider Engagement

The Kansas leadership team has attended 24 conferences in 2023 and has directly interacted with over 4,200 Providers year-to-date. We anticipate engagement with over 6,000 Providers by the end of 2023.

Through these touchpoints we heard from Providers that their workflows would be less burdensome through four key areas: (1) improve Provider portal user experience; (2) decrease PA requirements and turnaround times; (3) improve peer-to-peer processes; and (4) reduce post-pay audits.

Improve Provider Portal User Experience

To improve the Provider experience, in January 2024, we will be enhancing the Prior Authorization and Notification tool in our Provider portal to make it easier to navigate, reduce clicks and support faster submission. Feedback from preliminary Provider functionality testing includes "It's self-explanatory, everything I need is at the top" and "This is more clear and concise." In addition, we are implementing a new process to request reconsiderations via the Provider portal or direct electronic medical record (EMR) access, which will help avoid the need for unnecessary peer-to-peer reviews and appeals due to a missed page of records.

"When dealing with insurance companies on a daily basis, we far and above prefer to work with UnitedHealthcare. Their processes, handling of claims, portal, and timeliness are much better than competitors. In particular, our UHC provider representative is the best provider rep we work with."

– Casey J. Anderson, Consultant/Co-Owner
PHT Consulting & Billing, LLC

Decrease Prior Authorization Requirements and Turnaround Times

While PA remains an important tool to address clinical quality, safety and fraud, waste and abuse, we know that fewer PAs and decreased PA turnaround times can help streamline care delivery. We continually review our Kansas PA Code List to promote consistent clinical decisions about the safety and efficacy of care across all products and businesses. We regularly partner with other managed care organizations (MCOs), the state and care team stakeholders to review the validity of the PA list. As part of these efforts, in 2023 we eliminated the need for PA for 190 additional codes in Kansas.

Exceeding Expectations

Our KanCare compliance rate for timely approval exceeds 99% for standard requests and 97% overall. Our Kansas UM review timeframes exceed State requirements:

- Urgent – 0.69 days
- Nonurgent – 3.84 days
- Pharmacy – 0.02 days (30.75 minutes)

[redacted]

Improve the Peer-to-Peer Process

Peer-to-peer discussion with a medical director expedites resolution of any requests to reconsider the denial or limited authorization of requested services before initiating an appeal. We are enhancing our Provider portal to accommodate online scheduling for peer-to-peer, removing any need to call or wait on the phone. In addition, to accommodate peer-to-peer requests within 24 hours, we are adjusting our current staffing models to make certain Providers receive the level of service expected by Kansas. As part of this effort, we will continue to have qualified peers with the same specialty and/or subspecialty available to complete the peer-to-peer reviews. While all Providers are offered a peer-to-peer consultation within 24 hours, feedback from the Kansas Hospital Association indicated a desire to allow more time to schedule so we enhanced the process to extend the scheduling window from 72 hours to seven business days to schedule.

Reduce Post-Payment Audits

We provide a comprehensive suite of solutions to detect and prevent improper claims payment for health care services. Pre- and post-payment review methodologies verify appropriate utilization of services by identifying aberrant and excessive billing practices and trends, inappropriate treatment, fictitious and unqualified Providers and ineligible Members. Responding to Provider feedback regarding post-payment review and the inconvenience of overpayment recovery, we transitioned most of our UM claims review processes to pre-payment reviews in 2023. This process allows for review of medical records and itemized billing statements, ensuring claims payment accuracy and UM oversight while avoiding the administrative burden of overpayment recovery.

Data-Driven Utilization Management Processes and Innovative Contracting

For Providers, our innovative, data-driven UM processes and value-based contracts enable them to simply and easily submit PA in a way that does not create additional administrative burden. Providers have requested more dynamic and interactive ways to communicate, and we are committed to continued evolution, transparency, consistency and efficiency.

Our integrated clinical platform currently delivers a coordinated, integrated UM experience, features centralized PA management functions and user experience, and serves as a single source of truth for clinical operations transactional data. Currently, our UM team has EMR access connections with 22 facilities across Kansas, which reduces Provider administrative burden by

eliminating the need for Providers to fax or upload medical record documentation. Additional examples of how we are using UM innovation and automation to reduce Provider administrative burden while focusing on making sure Members have access to necessary services include:

Tool and Resource	Description
Decision at Point of Care (DPOC)	Decreases Provider burden by providing real-time confirmation of eligibility, instant validation of benefit coverage and automated medical necessity reviews. DPOC has automated decision tree questionnaires to rapidly confirm medical necessity per evidence-based clinical criteria, significantly reducing turnaround time. **Using DPOC is estimated save Providers 16 minutes per PA request** and enhances transparency and compliance with clinical policies, guidelines and best practices.
Smart Technology Authorization Request (STAR) Technology	A streamlined technology-driven process and interface for submission and review of medical necessity and clinical appropriateness for behavioral health inpatient admissions that uses key questions, data sets and algorithms specific to various diagnostic cohort groups. **Our per-review estimates demonstrate that a STAR review not requiring a care management intervention decreases the telephonic review time to less than 10 minutes from 35 minutes.**
Quick Code Look-Up	A Provider can use this feature to confirm if a service is covered, any site of service limitations and, depending on the EMR level of integration, can submit the authorization directly to UnitedHealthcare.
Point of Care Assist®	A multi-payer integrated EMR solution providing real-time information, such as care gap closure and treatment referral options. **Point of Care Assist is estimated to save Providers 16 minutes per PA.** The tool has been deployed with 121 TINs and more than 3,700 individual Providers in Kansas and continue to pursue expansion with other EMRs, including Cerner.
Pre-Check My Script®	Enables prescribers to use Kansas-specific medical necessity decision trees to request medication authorization in real-time. Through prescriber input at one of our internal Provider attended forums, we learned adding extra space for clinical details would be appreciated and allow prescribers to add additional documentation to support medical necessity. As a result, we updated our technology and educated Providers on adding additional clinical documentation for a more streamlined review process and quicker turnaround times. Providers receive instant approvals when medical necessity criteria are satisfied upon entry of required PA information.
Track It	A comprehensive Provider communication tool that efficiently manages health care operations. It flags missing data and tracks document submissions, claims status, reconsiderations, authorizations and more. Users can customize Track It to

Tool and Resource	Description
	receive portal or email alerts and monitor activity for various tasks, including PA; edits; pended claims; reconsideration and appeals; admission, discharge and transfer (ADT) and ED visit notifications; and credentialing and onboarding.

Reducing Provider Administrative Burden – P&T and DUR Committees

UnitedHealthcare's Pharmacy & Therapeutics (P&T) and Drug Utilization Review (DUR) Committees complement and support the decisions and directives made by the KDHE P&T and DUR Committees. Our DUR team is working with KDHE to refresh our retrospective DUR program to improve the quality of our Provider outreach and decrease the number of outreaches network Providers are asked to review. To help decrease Provider burden on the pharmacy PA process, our local pharmacy director works with our PA team to verify the electronic PA intake questions aligns with the questions on the KDHE P&T approved PA forms. This alignment ensures that the clinical information required for case review is collected at the beginning of the process, which decreases the need for additional information.

Value-Based Purchasing Agreements

It is critical for us to partner with medical, behavioral, ancillary and community-based Providers who specialize in the care of the Medicaid population and are invested in working together to deliver appropriate care. Our value-based payment (VBP) models help incentivize Providers to deliver needed care and improve health care quality and Member outcomes.

UnitedHealthcare commits to having 70% of our Members receiving services from VBP Providers by 2026, aligning our VBP programs with the State's goals and prioritizing Provider preferences in program design. We know from our experience that a one-size-fits-all, value-based approach is ineffective. Providers are at varying levels of capacity and readiness for managing value-based programs. To reduce Provider administrative burden in VBP programs, we use the following strategies:

- Educating Providers to understand how to effectively manage patient care in a value-based model, advance along the Health Care Payment Learning and Action Network continuum at a rate they choose and correct course when needed to keep Provider engaged
- Providing upfront incentive funding to support practice transformation and capacity building
- Aligning quality measures with the KDHE Healthy Kansans 2030 Report goals
- Sharing data insights in an intuitive format and providing detailed claims data for Providers who prefer to run their analytics
- Supporting practice staff with extra resources, such as dedicated RN and BH clinicians to support VBP Providers, to identify opportunities for practice transformation, improve quality and enhance cost efficiency
  - Clinical practice consultants (CPCs): Serve as clinical quality management experts to Providers, working collaboratively to review clinical practice guidelines (CPGs), deliver Provider Care Opportunity Report (PCOR) results and provide education and resources.
  - Clinical transformation consultants (CTCs): Help Providers reduce total cost of care, improve quality and Member satisfaction. The CTCs help identify, plan, implement and evaluate new care pathways and processes.

- Provider enablement consultants (PECs): Support BH Providers in improving individual and population outcomes, delivering person-centered care and moving Providers toward greater integration of physical and BH. Complementing the expertise and engagement of the Providers, PECs bring with them additional clinical decision support data (e.g., near real-time admission, discharge and transfer [ADT] and medication adherence information) that helps Providers better understand the holistic care needs for their patients.

Reducing Provider Burden – Streamlining Care Delivery Through VBP Strategies

Children's Mercy Pediatric Care Network (PCN) is an integrated pediatric network that coordinates the medical care of pediatric patients. We are contracted with PCN to provide services on a fully delegated, capitated agreement for all non-waiver children in Johnson, Wyandotte, Miami, Douglas, Franklin and Leavenworth counties. This VBP model reduces administrative burden for PCN by eliminating the need to request PA and improves the overall quality of care delivered to our Members. PCN uses an integrated team-based approach to care coordination to make sure the patient receives the right care, at the right time, in the right setting.

Using Data to Ensure Appropriate Utilization of Services

UnitedHealthcare uses our advanced data analytic capabilities to confirm appropriate utilization of services — identifying patterns, predicting outcomes and supporting data-driven decisions to improve the health of individual Members and the larger population. Our UM staff continually analyze claims utilization data to detect over- and underutilization, such as gaps in care, through data dashboards and routinely monitor ED reports, inpatient census, PAs, benefit exception requests and continuity of care requests across Members. In addition, we routinely monitor the following sources of utilization data to identify trends and proactively address concerns, in turn reducing Provider administrative burden:

- Comparing current and historical utilization data such as PAs, concurrent review and retrospective review data
- Monitoring appeals to make sure overturned decisions are factored into any revisions to our medical necessity definition and to identify Provider or staff training opportunities
- Evaluating local practices to identify Kansas-specific best practices

Our Provider and clinical teams analyze Provider complaints to identify trends in unusually high authorization denials and they work directly with those Providers to develop individualized solutions. Our approach includes conducting further research to determine if the root cause of denials is systemic or if other factors influence adverse determinations. We mobilize our Provider relations team to work with the Provider to discuss the root cause, provide education on correcting the issue and offer tools as needed. The team uses several resources to educate Providers on successfully submitting PA requests and keeps them informed about denial trends through webinars, town halls, newsletters and information in the Provider manual and monthly Provider network bulletins.

Hospital Inpatient Performance Report

We review the Hospital Inpatient Performance Report (HIPR) with our leadership and share the HIPR with leading Providers and their clinical teams within each hospital. This report reflects UM metrics of inpatient admissions, readmissions and LOS to provide focused data for particular MS-DRGs and individual physician opportunities to help health systems prioritize process improvement. In addition, we can compare performance against other Kansas facilities and

against regional facilities for UnitedHealthcare. These performance comparisons are used as part of the data analysis our Gold Card Program will perform to find the highest-performing facilities and identify facilities with outlier quality metrics which need remediation.

Provider Care Opportunity Report

The PCOR improves quality outcomes by providing useful Member data regarding underutilization and gaps in care. This report is shared with Providers via an online portal and by our CPCs during monthly Provider meetings. The PCOR is used to track progress toward identified goals and aids Providers in implementing strategies for Member engagement and gap closure. Updated monthly, the PCOR includes practice- and Provider-level detailed information along with Member details for adherence and nonadherence. Our PCOR provides practical feedback, making it easy for Providers to identify opportunities to improve utilization, reach benchmark goals and understand opportunities by Member, in addition to making sure each visit is more valuable to the Provider and their patient. For Providers in VBP arrangements, the PCOR includes analysis to help them reach incentive targets for additional earnings tied to incentivized metrics and/or quality improvement. In 2022, we acted on Provider feedback and redesigned our PCOR reporting from a Microsoft Excel format to a more user-friendly, portal-based format in Practice Assist and adding two-way communication between the CPC and the Provider.

Our Chief Medical Officer Dashboard

Our CMO Dashboard tool aids decision making and strategic initiatives to reduce Provider administrative burden, enhance plan performance, improve Member outcomes and collaborate with other KanCare MCOs and Providers to review opportunities to reduce PA requirements in alignment with **Scope of Services 7.8.3**. It includes population- and Member-level data, stratified and analyzed by variables such as race, ethnicity, language, gender, age and geography. The CMO Dashboard includes historical data for each measure, month-by-month comparisons, year-to-date rates, final rates from previous years and state and national percentiles. This data can be viewed from various perspectives, including county-level data, showing social determinants of health drivers in different counties. The dashboard's data allows for the development of specific plans for performance remediation, making it a comprehensive and efficient tool for health monitoring and management.

Admission, Discharge and Transfer Feed

The use of ADT alerts to confirm appropriate utilization of services and reduce Provider administrative burden is a critical component of our UM program. We exchange and integrate ADT data with Providers and the Kansas Health Information Network and KONZA National Network (KHIN/KONZA) in standard formats, custom formats and standard and nonstandard interfaces. A critical component of our framework is the employment of the Health Level Seven International (HL7) standards. HL7 allows different health information technology systems to share and send information using international health care informatics and interoperability standards, thereby reducing Provider administrative burden in establishing ADT exchanges.

Our UM and care coordination staff receive real-time ADT alerts in our integrated clinical platform. ADT alerts initiate authorization for inpatient admissions, thereby reducing Providers' need to fax or call. The data is used by care coordination staff to identify Members with complex conditions in real-time to engage them in the hospital or ED. ADT data is incorporated into our predictive analytics tool by using claims, ED and inpatient utilization and clinical data to identify

individuals in priority populations or with targeted conditions. These feeds are incorporated into daily bed census tools and care coordination reports.

Experienced Local Staff

Our UM program is supported by a Kansas-based clinical leadership team led by our CMO, who has direct oversight of UM in compliance with **Scope of Services 7.8** and works closely with our health services director, our BH executive director and our pharmacy director. This team has over 25 combined years of tenure with UnitedHealthcare. We staff our UM program with Kansas-licensed medical directors who work with local clinical leadership and have a strong knowledge of Kansas. All clinicians and physicians supporting UM functions in Kansas are licensed in accordance with **Scope of Services 7.8.1** and have completed Kansas-specific training on services available, local and state medical policy, information about barriers to seeking care and the needs of the culturally diverse Members we serve. Our locally based, Provider-facing teams look beyond the simple episode of care to guide their work so they can respond quickly to Kansas' needs. We accomplish this through weekly interdisciplinary team (IDT) review of complex cases during clinical rounds, including rounds with large hospital systems to assist with timely discharge planning.

"As a born-and-raised Kansan, my primary focus as CMO is to improve our Members' health care and social determinants of health needs so they can thrive and live the best life possible. I truly believe everyone deserves the best health care experience—and this core belief is what fuels me in my role with UnitedHealthcare. As a practicing clinician, it was important for me and my staff to be focused on the needs of our patients and this often meant working with MCOs to make sure our patients received the best possible care. With that experience, I'm able to understand Providers on a deeper level because I've been in their shoes. To me, it is extremely important that both our Members and Providers are treated with dignity and respect and the work we do here empowers them to make informed decisions and help improve the health care delivery system."

Dr. Teresa Wesley
Chief Medical Officer

KSKC23.948

It is the engagement of our local leadership team that sets the tone for accountability and mission. We are committed to bringing Provider concerns forward and addressing Provider burden, all while ensuring Member safety and appropriate utilization of services.

Reducing Provider Burden – Eliminating Post-Acute Prior Authorizations

Based on feedback our local provider advocates received from Providers through the PAC, Kansas Hospital Association and Provider Joint Operating Committee meetings, and review of initial denial rates for post-acute services (skilled nursing facility, LTAC and acute inpatient rehab), in 2022, we removed prior authorization for these services. This change reduced administrative burden for Providers, allowing them to direct admit Members to their facility without requesting prior authorization and waiting for a decision.

Utilization Management and Services

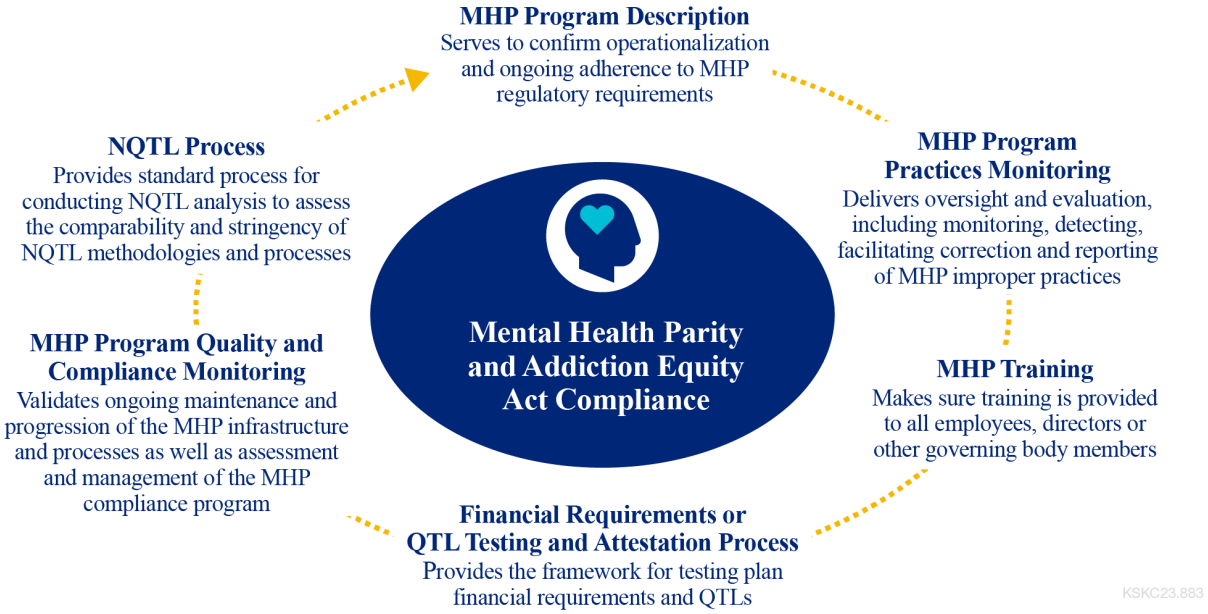
13. Describe the bidder's approach to developing and monitoring its Utilization Management program, in writing (e.g., policy, guidelines) and in operation, to ensure compliance with Mental Health Parity and Addiction Equity Act (MHPAEA).

UnitedHealthcare maintains a collaborative approach to developing and monitoring our UM program to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). We work with our network Providers and clinicians to address the needs of the KanCare program. This approach, guided by the UnitedHealthcare Utilization Management Program Description (UMPD) and the medical policies of UnitedHealth Group, consistently aligns with our commitment to person-centered care. Our national team dedicated to Mental Health Parity (MHP) stays informed about any legislative changes and works year-round assessing national and state-specific processes "in writing" and "in operation" for compliance with MHPAEA. With a strong technology infrastructure, intensive staff training and monitoring, and comprehensive MHP policies and procedures, we have developed an environment that supports mental health and addiction equity, as seen in Figure 13-1.

Parity Monitoring
UnitedHealthcare Community Plan of Kansas has never had an external MHP audit finding.

KSKC23.748

Figure 13-1. Mental Health Parity Policies and Procedures



Our Utilization Management Program

Improving population health requires attention to comparable access to both behavioral and physical health care. Our medical and behavioral UM policies and procedures align with the requirements found in the MHPAEA of 2008 and the subsequent release of Final Rules for Medicaid Managed Care Organizations (MCO) in May 2016, and all requirements issued by CMS and KDHE.

Our medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) UMPDs are the foundation for the objectives and guidelines of the Kansas UM strategy. We cover medically

necessary M/S and MH/SUD services and technologies (e.g., interventions, devices, medically administered M/S and MH/SUD drugs and more). Medical necessity refers to the principle that health care services, technologies and treatments should be in accordance with generally accepted standards of medical practice — appropriate for the Member's disorder, disease and symptoms; cost-effective; and essential for diagnosing, preventing or treating a medical condition. The concept of medical necessity considers the best interests of the Member and the evidence-based standards of medical practice, which helps make sure health care resources are allocated efficiently and Members receive appropriate care for their needs.

Mental Health Parity Compliance – In Writing

We consult with health care professionals (physical health, behavioral health [BH], pharmacy, dental) through our Kansas Provider Advisory Committee (PAC) to adopt medical necessity criteria and develop internal clinical policies for use in Kansas. Our Kansas PAC provides input as appropriate to our Kansas Healthcare Quality and Utilization Management (HQUM) Committee. The Kansas PAC and HQUM Committee formally review and approve our external, third-party M/S and MH/SUD medical necessity criteria for adoption for the KanCare program at least annually or when the national Utilization Management Program Committee (UMPC) approves changes. If the PAC or HQUM Committee identifies Kansas-specific changes to external criteria are needed to meet the needs of the KanCare program, they may make a recommendation to the UMPC. The UMPC reviews the recommendation and determines if the external criteria should be updated or if we will implement an exception to the medical necessity criteria based on Kansas-specific considerations. We provide transparency to Providers by publishing our M/S and MH/SUD medical necessity criteria on our Provider portals.

Comparable Processes

When developing and approving medical necessity criteria, both M/S and MH/SUD committees consider the following categories of sources (with source-specific differences if the source is specific to M/S or MH/SUD):

- Well-designed, evidence-based studies
- Observational studies
- Case studies
- Consensus statements
- Clinical and professional opinion papers

As outlined in the following table, our M/S and MH/SUD UM operational policies and procedures are comparable and MH/SUD policies and procedures are no more stringent than the M/S policies and procedures. All M/S and MH/SUD internally developed clinical policies follow the same development processes and are reviewed at least annually.

Comparison of UnitedHealthcare Utilization Management Operational Policies	
Medical/Surgical	**Mental Health/Substance Use Disorder**
UnitedHealthcare Hierarchy of Clinical Evidence: Outlines the hierarchy of clinical evidence used to determine which M/S health services or technologies are safe and effective and, therefore, eligible for benefit coverage.	**Optum BH Hierarchy of Clinical Evidence:** Outlines the hierarchy of clinical evidence used to determine which MH/SUD health services or technologies are safe and effective, making them eligible for benefit coverage.
UMPC Charter: Outlines the purpose, responsibility, functions and composition of the committee that oversees the M/S UM program review.	**Clinical Quality and Operations Committee Charter:** Outlines the purpose, structure, responsibility and membership of

Comparison of UnitedHealthcare Utilization Management Operational Policies	
Medical/Surgical	**Mental Health/Substance Use Disorder**
	the committee that oversees the Clinical Technology Assessment Committee (CTAC).
Medical Technology Assessment Committee (MTAC) Charter: Outlines the purpose, responsibility, structure and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for M/S.	**Clinical Technology Assessment Committee (CTAC) Charter:** Outlines the purpose, structure, responsibility and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for MH/SUD.
Applying Benefit Plan and Review Criteria Standard Operating Procedure: Outlines the hierarchy of authorities to be reviewed (i.e., state and federal laws and regulations followed by benefit plan criteria) when making clinical coverage determinations.	**Management of BH Benefits:** Describes the mechanisms and processes designed to promote consistency in the management of BH benefits.
UMPD of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company: Documents the philosophy, structure and standards that govern our medical management, UM and utilization review responsibilities and functions.	**BH UMPD:** Foundational document for the objectives and guidelines of our BH UM strategy.
Clinical Review Criteria Operational Policy: Documents that we will use evidence-based clinical review criteria to support clinical review decisions for UM programs and make sure there is consistent application of the clinical review process.	**Clinical Criteria Development Selection and Application Policy:** Addresses Optum's selection, development and use of clinical criteria in making benefit determinations.

Mental Health Parity Compliance – In Operation

Conducting Medical Necessity Reviews

The M/S and MH/SUD clinical reviewers follow a hierarchy of authority when making medical necessity determinations. The M/S Peer Clinical Review Operational Policy and the MH/SUD Management of BH Benefits Policy outline the processes. Both M/S and MH/SUD clinical reviewers review state and federal laws and regulations, followed by plan documents when making clinical coverage benefit determinations. Internally developed clinical policies or externally developed third-party medical necessity criteria are then reviewed. The criteria chosen for review are based on the treatment type, diagnosis and services requested.

Creating Consistency

In 2022, our Inter-Rater Reliability (IRR) M/S results were 97.56% and MH/SUD results were 96%, demonstrating that M/S and MH/SUD clinical reviewers comparably applied medical necessity criteria when making UM determinations.

Our M/S and MH/SUD clinical reviewers make medical necessity determinations using the KanCare medical necessity and appropriateness criteria and KDHE UM criteria for pharmacy/medical injectables as their primary resource. In the absence of KanCare policies, our

clinical reviewers rely on externally developed, evidence-based medical necessity criteria (e.g., InterQual®, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII). When M/S or MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs) fall outside the scope of both KanCare policies and externally developed medical necessity criteria, we use our internally developed, evidence-based, medical and behavioral national clinical policies.

Clinicians use their independent clinical judgment when they evaluate whether a Member's clinical condition meets medical necessity criteria. We generally assess the appropriate application of medical necessity criteria in operation through the results of our annual, mandatory M/S and MH/SUD Inter-Rater Reliability (IRR) assessment outcomes. All M/S and MH/SUD clinical staff and peer reviewers who make clinical coverage benefit determinations are required to participate in an IRR assessment annually. Clinical staff are required to achieve a passing score of at least 90%. Areas of improvement are identified for clinical staff who do not achieve a passing score and additional training is provided on the use and application of the relevant policies.

Utilization Management Program Oversight

The UMPC is responsible for oversight of the UM program and the development and maintenance of the scope and processes for our prior authorization, concurrent review and post-service reviews. This oversight includes defining the services that require UM reviews. The UMPC is guided by the UnitedHealthcare UMPD and medical policies of UnitedHealth Group. Functions of the UMPC include, but are not limited to:

- Oversight of our UM program
- Review and approval of services added to and removed from all our prior authorization review lists
- Oversight of the development and implementation of UM review processes to include processes to submit and adjudicate UM requests, confirm appropriate clinical review of UM cases and verify compliance with our MHP policies and procedures in UM reviews
- Promotion of compliance with regulatory and accreditation medical management requirements
- Review of and feedback on UM quality improvement activities, including the annual UM Program Evaluation
- Maintenance of approved records of all committee meetings

As outlined in the following table, our M/S and MH/SUD UM committee oversight structures and outcomes are comparable.

Mental Health Parity Committee Oversight, Composition and Outcomes	
Medical/Surgical Medical Technology Assessment Committee (MTAC) Committee Oversight	**Mental Health/Substance Use Disorder Clinical Quality and Operations Committee (CQOC) Committee Oversight**
▪ Our M/S MTAC assesses and approves the use of externally developed clinical criteria for M/S services. ▪ They use scientifically based, clinical evidence and the UnitedHealthcare	▪ The MH/SUD CQOC assesses and approves the use of externally developed clinical criteria for MH/SUD services. ▪ The CQOC uses scientifically based, clinical evidence and the BH Hierarchy of Clinical

Mental Health Parity Committee Oversight, Composition and Outcomes	
Medical/Surgical Medical Technology Assessment Committee (MTAC) Committee Oversight	**Mental Health/Substance Use Disorder Clinical Quality and Operations Committee (CQOC) Committee Oversight**
Hierarchy of Clinical Evidence in its assessment and approval processes. ▪ The MTAC conducts timely processes to verify transparency and consistency and to identify safe and effective M/S services and technologies.	Evidence in its assessment and approval processes. ▪ They conduct timely processes to verify transparency and consistency and to identify safe and effective MH/SUD services.
M/S MTAC Committee Composition	**MH/SUD CQOC Committee Composition**
Medical directors with diverse medical and surgical specialties and subspecialties, representatives from business segments, legal services, consumer affairs, medical policy development and operations teams, benefit interpretation team and others	Representatives from subcommittees, the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, Provider experience, accreditation and benefits teams
M/S MTAC and MH/SUD CQOC Committee Review Outcomes	
Through these reviews, the committees: ▪ Develop evidence-based position statements on selected medical technologies. ▪ Assess evidence supporting new and emerging technologies. ▪ Review and approve clinical criteria within new or existing medical policies. ▪ Review and maintain externally licensed guidelines. ▪ Consider and incorporate nationally accepted consensus statements and expert opinions into the establishment of national standards for UnitedHealth Group. ▪ Promote consistent clinical decisions about the safety and efficacy of care across all services. ▪ Communicate approved policies internally and externally. ▪ Review and approve utilization review and CPGs to align with internally developed medical policies and the UnitedHealthcare Hierarchy of Clinical Evidence (includes internally developed guidelines, nationally recognized guidelines and specialty society guidelines). ▪ Review and approve medical and guidelines-related policies and procedures annually.	

UnitedHealthcare's Mental Health Parity Program Compliance

Our MHP governance committee structure includes M/S and MH/SUD cross-functional representatives in our joint parity oversight team to oversee MHP infrastructure adherence, including ongoing review of operational and organizational policies, processes and associated data that relate to, or affect compliance with MHPAEA. This forum reviews analyses and outcomes, provides direction, reviews quality monitoring results and identifies any process improvements.

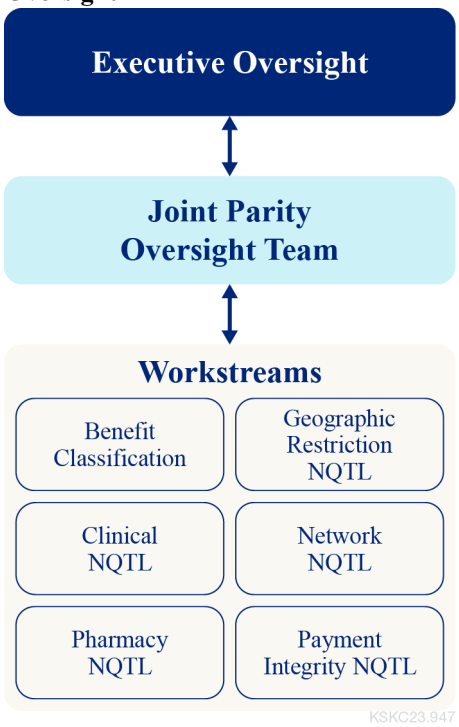
Compliance with Non-Quantitative Treatment Limitations

We are compliant with the MHPAEA regulations that "prohibit a plan or an issuer from imposing Non-Quantitative Treatment Limitations (NQTL) on MH/SUD benefits in any classification unless, under the terms of the plan or coverage as written and in operation, any

processes, strategies, evidentiary standards or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation to M/S benefits in the same classification."

The NQTLs are defined as processes, strategies, evidentiary standards or other factors that limit the scope or duration of benefits for services provided under the plan. We identify NQTLs by reviewing benefit plan designs and operational processes across benefit classifications to determine whether they limit the scope of benefit coverage, or the duration of treatment covered under our plans.

Figure 13-2. Mental Health Parity Oversight



We maintain policies and procedures that describe the process for evaluating new operational processes and benefit plan designs, and developing, updating and maintaining NQTLs. Our dedicated NQTL workstreams report into our joint parity oversight team, as shown in Figure **13-2**, and are responsible for performing regular evaluations of relevant business area policies, operational processes, and associated outcomes data to make sure the scope of work in the respective content area (i.e., benefits, clinical, network, pharmacy and payment integrity) is in alignment with our parity standards and specific regulatory requirements. The NQTL workstreams help align strategies, methodologies, and processes to make sure they are comparable and applied no more stringently to MH/SUD benefits than to M/S benefits "as written" and "in operation." The workstreams are led by M/S MHP operations team staff with MH/SUD MHP staff and regulatory adherence team support. National and local Kansas operational or business area accountable owners (e.g., the local Kansas CMO for the Clinical NQTL workstream) attend the NQTL workstream meetings and providing input. The workstreams facilitate monitoring of MHP compliance through review of business and clinical operational area policies, processes, and procedures (i.e., Kansas-specific policies) using a standard and continuous review process. Through analysis, the workstreams draw conclusions and identify next steps.

Compliance with Quantitative Treatment Limitations

Our team works directly with finance and actuarial teams to analyze quantitative treatment limitations (QTLs) and confirm the financial limits imposed on MH/SUD benefits are comparable to and no more stringently applied than those imposed on M/S benefits. The continuous process employed by UnitedHealthcare and Optum Behavioral Health has brought together M/S and MH/SUD subject matter experts in benefits and operations to conduct ongoing review of plan design and application of plan terms and conditions that constitute the QTLs.

Ensuring Compliance Through Dedicated Resources

We maintain dedicated resources responsible for confirming ongoing adherence to MHP regulatory requirements. The scope of the MHP program consists of a series of principled standards and the continuum of policies and procedures associated with the integration of parity processes into our business practices and maintaining MHP compliance according to the regulations. The program aligns with regulatory guidance and the provision of quality care for our Members. Our program aligns with the MHPAEA of 2008 and the subsequent release of Final Rules for Medicaid. The program includes:

National Parity Expertise

Our MHP team includes BH clinicians who are fully focused on assessing national and health plan-specific processes in writing and in operation for MHPAEA compliance. This highly tenured team has more than 100 years of combined health plan regulatory support experience across all areas of managed care.

- Governance and oversight of the necessary infrastructure and processes to be parity aligned
- Designating MHP standards as the basis for policies and processes created, revised and implemented
- Facilitating regular assessments of operations and policies, and continuous updating and actions taken because of the review
- Reviewing and analyzing changes to benefit packages, service delivery structures, operational requirements and policies to confirming ongoing parity compliance
- Monitoring parity compliance in operation, including establishing and reviewing relevant metrics and outcomes data to identify potential parity compliance concerns
- Overseeing improvement actions taken due to the review
- MHP quality monitoring, continuous program improvement and training

Responsibility for compliance with state and federal MHP statutes and regulations is our obligation working with Optum Behavioral Health as UnitedHealthcare's affiliated subcontractor for BH services. Local engagement is an essential component of the MHP program. The Kansas chief executive officer, compliance officer, CMO and BH executive director work in partnership with our national MHPAEA subject matter experts, supporting the MHP team's assessment of MHPAEA compliance.

UnitedHealthcare's national team dedicated to MHP oversees, manages and maintains our MHP infrastructure and processes to support MHP compliance. Our MHP team reports into our clinical executive hierarchy and is accountable for the strategic approach to executing our MHP business objectives. This team works with UnitedHealthcare national functional partners such as clinical services, compliance, regulatory, legal, pharmacy, network, benefits and payment integrity.

Mental Health Parity Operations Team

The MHP operations team is part of our national clinical oversight team and is accountable for executing MHP business objectives. The MHP operations team facilitates integration of MHP requirements and processes into regular business practices, operational policies and state-specific business segments. The MHP operations team acts as a liaison to multiple designated departments, functional and business areas across the enterprise to assess processes, both in writing and in operation, to maintain or refine policies and procedures, and to support ongoing internal parity monitoring and related corrective action and remediation, as indicated. The MHP operations team prepares responses to MHP inquiries, audits and exams.

Regulatory Adherence Mental Health Parity Team

The regulatory adherence MHP team facilitates MHP regulatory research with the ability to understand and operationalize state and federal laws and to collect, monitor and document changes to requirements to achieve regulatory adherence and mitigate risks. As MHP subject matter experts, they support enterprise-wide MHP training, communication and education and conduct monitoring activities to assess the consistency with which program policies are operationalized and implemented. The regulatory adherence MHP team oversees the annual evaluation of the MHP program and related policies and procedures.

Mental Health Parity Staff Training

In accordance with MHPEA, we offer MHP training through our enterprise-wide learning platform to all employees, directors or other governing body members, agents and other representatives engaged in functions that are subject to federal or state MH/SUD parity requirements or involved in MHP analysis. The MHP team, in collaboration with UnitedHealthcare and Optum Behavioral Health compliance leadership, reviews staff alignment to confirm the appropriate individuals are identified for inclusion in the annual required trainings. Our MHP training includes MHP requirements, program governance structure and relevant changes in MHPAEA legislation. Training occurs at least annually and is part of new hire onboarding. Training completion is monitored, and attestation is required upon completion. The MHP team reviews and updates the training annually, so the content reflects current regulatory requirements.

Mental Health Parity Quality Monitoring and Reporting

The MHP program functioning is assessed regularly to validate consistency with the MHP program's documented processes. Quarterly quality monitoring confirms ongoing maintenance and quality improvement of the MHP infrastructure, processes and completion of NQTL Workstream activities per the MHP Workplan. All monitoring results are reported to the appropriate internal and external oversight committee(s) and governing bodies as required. We participate in and respond to state inquiries or mandated annual reporting requirements regarding NQTL and QTL analyses.

Utilization Management and Services

14. Describe the bidder's ability and approach to collaborating with the State to design, implement, and evaluate pharmaceutical initiatives and best practices. In addition, describe in detail at least one data driven, innovative clinical initiative that the bidder implemented within the past thirty-six (36) months that led to improvement in clinical care, including how improvement was measured, for a population comparable to the ones described in the RFP.

Collaborating with the State on Pharmaceutical Initiatives and Best Practices

Recognizing the State, Providers and pharmacies face financial and administrative burdens amid an ever-changing pharmaceutical services landscape, we manage the provision of pharmaceutical services as a trusted, transparent and valued partner to the State. Our team serves as a knowledgeable and experienced resource to support the State's pharmacy program. To advance our mutual goals for providing quality, cost-effective and compliant pharmaceutical services to KanCare Members, our Kansas-based clinical care and pharmaceutical services teams employ a data-driven approach and benefit administration capabilities to design, implement and evaluate best practices and pharmaceutical initiatives.

In the following narrative, we describe our approach to collaborating with the State to:

- **Design** pharmaceutical initiatives and best practices specific to the KanCare program
- **Implement** initiatives and best practices the State and its designees have reviewed
- **Evaluate** the efficacy of our pharmaceutical initiatives and best practices

Following these descriptions, we provide details on three innovative clinical initiatives we implemented within the past 36 months that were successful in improving health outcomes.

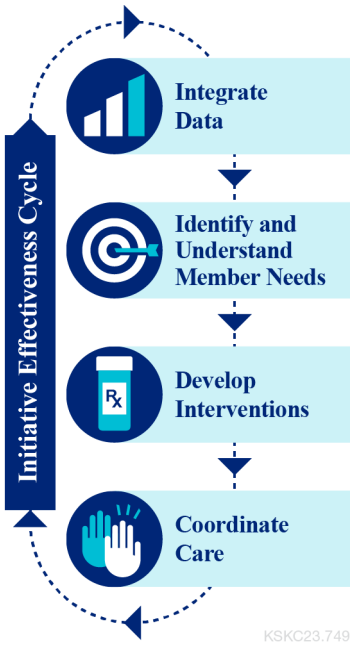
To maintain business continuity, pharmacy program integrity and to benefit from economies of scale of high-volume services, such as benefit management and information technology operations, we use our own UnitedHealth Group affiliates with the same standards of integrity and quality oversight. For pharmacy benefit management (PBM) services under this KanCare Contract, OptumRx is our affiliate subcontractor.

Our Kansas-based pharmaceutical director, Michael Porterfield, Pharm.D., is an integral member of our leadership team who guides our ongoing collaborative approach to managing pharmacy services for our KanCare Members. He serves as accountable owner, key contact and liaison with the State regarding OptumRx performance and our quality performance and contract compliance activities. Our pharmaceutical director participates in the State's clinical, preparatory and oversight meetings such as the Pharmacy & Therapeutics (P&T) Committee, Drug Utilization Review (DUR) Board, KanCare clinical team, Mental Health Medication Advisory Committee (MHMAC), Psychotropic Medication Workgroup and Advanced Medical Hold Manual Review (AMHMR) to provide input and support on designing optimal pharmaceutical initiatives and best practices for Members, Providers and the State. We actively participate in these committees and listen to and engage our partners at ad hoc meetings that occur when we need to address an issue outside our standard meeting cadence.

Designing Pharmaceutical Initiatives and Best Practices

In partnership with Kansas-based pharmaceutical Providers, local and national teams, we use targeted data resources and collaborate in a consultative manner with the State and its designees to design, implement and evaluate best practices and pharmaceutical initiatives. To inform the design of a new initiative, we first identify an opportunity or trend requiring further investigation. Then, we conduct analyses to discover the root cause. Analysis results inform our next steps in the design phase, which includes sharing information with the State and discussing potential solutions to implement.

Figure 14-1. Initiative Effectiveness



The figure depicts the cyclical pattern we follow to make sure our interventions and initiatives are effective and systemically integrated at every Member, Provider and administrative touchpoint for synchronized whole-person care. Whether an initiative originates from the State, local advisory committees, workgroups or our team, we apply our data gathering and analytics techniques and prepare potential solutions to share with the State and stakeholders. To fully understand the extent and scope of a trend or issue, we gather data and analyze it, then share findings with our partners to develop solutions. The resources and assets we use to design effective initiatives and apply best practices include:

- **Data Analysts:** We have dedicated teams of clinical and medical economic analysts who support our pharmaceutical director. They work with our Kansas-based clinical and pharmaceutical services teams to build modeling programs for program-specific data mining exercises, analytics reporting and predictive modeling purposes.
- **Data Mining:** Collecting data from multiple sources, our data analysts have a clear line of sight into and across areas to identify opportunities where we can collaborate with the State and stakeholders to address issues relevant to the program or at population-specific levels. Data sources analyzed include pharmacy claims, medical claims and prior authorizations across internal and subcontractor platforms.
- **External Data Sources:** Our pharmacy team incorporates external data sources in designing and implementing initiatives and best practices. A key external data source example is prescription data provided by the State's Prescription Drug Monitoring Program (PDMP) known as K-TRACS. The K-TRACS data, which contains information regarding all controlled substance prescriptions filled, is used to inform initiatives such as the lock-in program and can be used to inform and direct care management activities for Members with substance use disorder. This visibility into Member controlled substance activity provides a well-informed review to validate Members are not included or excluded inappropriately.

After discussing ideas, gathering input about the initiative and gaining buy-in from collaborators, our pharmaceutical director leads its implementation and serves as the key point of contact throughout the process. When we work with KDHE on revisions to their prior authorization guidelines, for example, our pharmaceutical director takes the proposed recommendations,

confers with our clinical team about the changes and solicits feedback to share with the State. He then leads the implementation based on the State DUR Board's approval of the final criteria.

UnitedHealthcare Data Technologies Used to Identify Intervention Opportunities

To analyze data and identify Members who would benefit from participation in clinical initiatives or interventions, we use various analytic resources. Our Hotspotting tool and Impact Pro® are resources our data analysts use to collect and analyze data.

- **Hotspotting tool** takes a claims-driven approach to quickly identifying utilization trends for member-focused intervention. With our Hotspotting tool, we source data from all claims sources (e.g., Providers, subcontractors, facilities), 834 enrollment files, the Member's enrollment in care management program(s) and Impact Pro. With data refreshed at least monthly, this tool enables our quality improvement, clinical care management and care coordination teams to target individual Members or Member groups for interdisciplinary team intervention and engagement. Our clinical care teams monitor the interactive heat map and use it to analyze Member cohorts by risk factors, demographics, care delivery setting, diagnosis, utilization, cost and other factors. With the data consolidated using our Hotspotting tool, we can filter and sort at programmatic, population and individual Member levels to inform our initiatives for improving Member health outcomes. For example, the dashboard view compares cohorts, including details such as frequent ED use and indications of drug seeking behavior. Also, we will use our Hotspotting tool as part of our Pharmacy Telehealth Hub initiative to identify Members who could benefit from accessing primary care services at a pharmacy telehealth hub.

- **Impact Pro** is an advanced analytics engine we use for risk stratification and predictive modeling purposes across physical, behavioral, pharmacy and social determinants of health (SDOH) risk factors to identify care coordination and care management opportunities. Its stratification is based on the two pillars of clinical risk factors incorporating a suite of pharmacy data points such as medication adherence gaps and contraindicated medications. Impact Pro has over 1,500 criteria for risk stratification and 300 rules across clinical risk indicators (e.g., multiple chronic conditions, polypharmacy) and Member outreach opportunities (e.g., inappropriate ED use, suicide risk, inconsistent medication refills). For pharmacy services, we use Impact Pro to identify Members with upcoming evidence-based medicine gaps in care for early intervention, such as contraindicated medications and opioid use disorder and opioid overdose history without medication-assisted treatment (MAT) and other pharmacy risks.

Using these tools, our analysts examine prescribing patterns and help our pharmacy and clinical teams to understand population health pharmacotherapy trends impacting Members.

A Best Practice Highlighting Our Pharmaceutical Initiative Process in Action

Data Analytics: Using pharmacy claims data, we conducted an economic impact study regarding Humira®. The study showed that the State paid $8.5 million for Humira® in 2022 for KanCare Members.

Sharing Information and Discussing Solutions: At a monthly meeting with the KDHE pharmacy team, our pharmacy director presented the Humira economic impact study we conducted. Knowing the patent for Humira would be ending in January 2023, our pharmacy team evaluated the release of biosimilar formulations of Humira on State drug expenditure. Our team shared projections, based on claims data, showing that including biosimilars on the KDHE formulary should result in net savings to the State and would cost pharmacies less to purchase. The Humira biosimilars offer up to an 85% discount at the point of sale for pharmacies and overall net of rebate savings of about 45% to the State. With the alternatives costing less to purchase, pharmacies could see improvements with their cash flow. As we received additional pricing information on biosimilar alternatives, we evaluated and refined our projections and shared the results at later meetings with the KDHE pharmacy team.

Implementing the Initiative: Due to this collaborative effort, KDHE expanded its formulary to include Humira biosimilars effective Nov. 1, 2023. We will evaluate the impact of this pharmaceutical initiative by tracking new users of the biosimilars and measuring against Humira's historical utilization. We plan to build on this initiative in partnership with the State to educate Providers on the benefits of the biosimilars.

Implementing Pharmaceutical Initiatives and Best Practices

Through our local pharmacy team, clinical pharmacy management team and with our affiliate PBM, OptumRx, we implement initiatives and best practices. Our local pharmaceutical director is the key contact and liaison who shares information with the State and stakeholders and oversees completion of tasks and process changes tied to the initiatives. For example, our KanCare pharmaceutical director:

- Coordinates with the State to provide input regarding the review of new drugs to market and changes to the Preferred Drug List (PDL), prior authorization and benefit criteria
- Oversees the DUR programs and Medication Therapy Management (MTM) program for our KanCare Members
- Provides KDHE contractually required utilization data reporting and ad hoc requests
- Submits to the State data trend analysis and potential affordability opportunities pertaining to overall pharmacy expenditures for the KanCare program
- Confirms compliance with the Contract and the State's policies
- Makes sure required reports are delivered to the State (e.g., MTM, AMHMR and applicable fraud, waste and abuse reporting) according to the State's specifications

Throughout the initial implementation phase and after activation, the clinical pharmacy management team uses data mining, analytics and clinical care team input to further ideate, redesign and manage the initiative.

With every KanCare program pharmaceutical initiative, we use medical and pharmacy claims to identify Members eligible for the initiative (e.g., MTM services). Our clinical pharmacists check the Medi-Span drug database as a resource to build DUR rules and algorithms. We use external sources such as the PDMP to look for questionable controlled substance prescribing. Ongoing, our DUR Board and P&T Committee review DUR initiatives and best practices during their scheduled meetings, where they make decisions or offer guidance to improve outcomes as needed. Also, our partnerships with local community pharmacists via our MTM program conduct

comprehensive medication reviews, targeted medication therapy management interventions or close gaps in care.

Communicating with the State throughout Initiative Implementation

For continuity of care, communication and sharing information is a critical part of our collaborative approach to implementation. In keeping with the State's priority to implement and deliver high caliber initiatives and pharmaceutical services to our Members, our pharmacy team manages processes and communication activities to:

- Monitor and address misuse or abuse of the pharmacy benefit, including referrals to the pharmacy lock-in program where appropriate
- Institute appropriate pharmacy benefit, care management roles and MTM guidelines
- Collaborate with State designees and other MCOs to facilitate a consistent experience for Members, prescribers and pharmacies while identifying opportunities for process and program improvement to increase Member satisfaction
- Implement strategies to identify and address noncompliance with the PDL, prior authorization requirements, claims filing and appropriate prescribing practices
- Participate in State-led meetings, committees and workgroups to define roles and responsibilities for collaborating with the State on additional initiatives
- Communicate feedback and lessons learned to improve processes or apply best practices such as taking suggestions for improvement of clinical guidelines from the prior authorization team back to KDHE

Throughout the implementation phase and after go-live of a new initiative, we continue to monitor performance and outcomes to make improvements. We share information and experience with our State partners via reporting or updates at scheduled or ad hoc meetings.

Communicating with Members and Providers throughout Initiative Implementation

When implementing a State-driven initiative or best practice, we use State-provided materials and collaborate to create and disseminate additional Member and Provider materials. If we are leading an initiative or implementing a best practice where new materials need to be created, we submit relevant program information and materials in the specified format for review and approval before use. Our local pharmaceutical director will lead creation and update of pharmacy-related member materials, provider manuals, provider directories, newsletters and information for our public websites. For example, our pharmaceutical director leads collaboration with our DUR team to revise the retrospective DUR letters we send to our network Providers, including obtaining messaging input and approval from KDHE.

If the Member is receiving care coordination services, their dedicated care coordinator incorporates pharmacy information into the Member's person-centered service plan or plan of service to avoid any disruption in Member prescription coverage and medication therapies. The care coordinator provides Members with coordinated and proactive communication, including a point of contact who can expedite any questions or concerns in obtaining needed prescriptions or prior authorizations.

To streamline workflows and reduce pharmacy and prescriber administrative burden, our systematic processes and best practices enable:

- Providers to submit prior authorization requests electronically
- Customized claims system edits for each initiative, such as quantity limits, prospective and concurrent DUR edits, diagnostic inclusion or exclusion requirements and prior authorization requirements
- Documentation and tracking of information for Members receiving care management services
- Notifications and bulletins to be posted on our websites and portals for ease of access for Members and Providers
- Electronic delivery of state-approved documents and educational information
- Automation of prior authorization reviews, when approved by the State and per clinical guidelines

Our provider and member services team leads will use approved materials, such as training presentations and FAQs, to train our member service advocates and provider advocates (i.e., call center and outreach staff) on communication with Members and Providers regarding the initiative, including warm transfer protocol and responding to Member and Provider inquiries during and after business hours.

Using Technology to Enable Providers to Apply Best Practices in Pharmaceutical Care

To assist Providers and pharmaceutical Providers to manage safe medication therapies for Members, we implement DUR best practices that focus on reviewing medical and pharmacy information against current evidence-based guidelines. Two examples are Gaps in Care and DUPLIMIT:

- **Gap In Care alerts** are part of our retrospective DUR program. Systems-generated Gap in Care alerts advise Providers if a Member should be on a specific therapy, based on diagnoses found in claims, but the medication is not in the Member's pharmacy profile. For example, if the Member has heart failure and an anticoagulant has not been prescribed, the Provider will receive a Gap In Care alert containing this information. **For federal fiscal year 2022, 14% of identified Gaps In Care identified in our KanCare membership were successfully closed.**
- **DUPLIMIT** is a concurrent drug utilization software program and best practice that will go-live for our KanCare Members on Feb. 1, 2024. For Member safety, we use DUPLIMIT to alert pharmacists and prescribing Providers of therapeutic duplication scenarios so they can establish medical necessity of each medication and adjust prescriptions as needed. At the point of sale (POS), DUPLIMIT monitors the Member's medication profile for concurrent utilization of two medications from the same drug class. When a prescription is submitted for a drug that is considered duplicate therapy, the pharmacy receives a message asking the dispensing pharmacist to investigate the duplication and submit appropriate outcomes codes.

DUPLIMIT Makes a Difference

During the first three quarters of 2023, using DUPLIMIT, enabled pharmacies that were in the process of refilling prescriptions that reached the override limit to resolve the duplicate therapy issue **in 92% of these cases — without needing to request prior authorization**. This high resolution rate without prior authorization signifies discontinuation of one of the duplicate drug therapies identified and DUPLIMIT's effectiveness. The DUPLIMIT program not only avoids potentially harmful duplicate therapies to promote patient safety and effective therapies, but also results in cost savings for state Medicaid programs.

If medical necessity is verified, the POS pharmacy will have a limited number of override allowances per specific therapeutic duplication. If after the designated number of overrides on subsequent prescription claims is exhausted, it indicates potential inappropriate prescribing. This will generate a prior authorization requirement to confirm additional refill requests and continued concurrent use is medically necessary. With DUPLIMIT programming, these duplicate fills are identified even if multiple pharmacies are filling the prescriptions. With the Member's safety as the priority, DUPLIMIT alerts happen in real time and at POS, which facilitates safe medication dispensing and assists the pharmacist in giving clear directions to the Member for taking the prescribed medications. An example of how DUPLIMIT promotes safety is when a Member has a blood clot and their doctor changes a prescription from one anticoagulant to another. If the Member continues to get both anticoagulant prescriptions filled, DUPLIMIT alerts the pharmacy to prevent a health hazard for the Member.

Evaluating Pharmaceutical Initiatives and Best Practices

To curtail inappropriate use of medications and assess the efficacy of recently implemented initiatives in achieving desired outcomes and cost savings, we use a combination of data analytics tools and input from Members, Providers and others. For example, we analyze utilization data and review feedback from our Members, Member Advisory Committee (MAC), Providers, State designees and internal staff.

The data tools and assets we use in the design phase are the same tools we use to evaluate our best practices and initiatives. Depending on the best practice or program design, we gather input and feedback from Members, Providers, external partners and the State. Our designated pharmacy data analytics team measures outcomes and provides reports to our clinical care team, including our pharmaceutical director. In addition to evaluating the initiative's level of success, they use the data for targeted Provider and Member outreach or messaging as needed. We share our evaluation information, outcomes and best practices with our internal colleagues and stakeholders and externally with the State via reporting, responses to State inquiries and open discussions at established and ad hoc meetings.

Reporting Outcomes to the State and Federal Regulators

As part of our ongoing approach to quality and utilization management, our local pharmacy team collaborates with State personnel to confirm accurate annual reporting of DUR activities to CMS. This annual report documents initiatives and evaluates outcomes of various pharmacy programs and best practices. This ongoing exchange of information and data enables the State and our local leadership to make informed decisions regarding pharmaceutical utilization policy effectiveness. Our pharmaceutical director presents key information from this annual CMS DUR Report for evaluation and discussion annually at the KDHE Drug Utilization Review Board meeting.

Subcontractor Quality Oversight

Evaluating the quality of our pharmacy program is integral to our continuous quality improvement approach with our subcontractors. We confirm that OptumRx performance quality is no less than if our Kansas Medicaid health plan performed the services in-house. OptumRx is equally held to contractual performance standards and subject to performance monitoring and oversight activities. Subcontractor oversight activities are integrated within our Quality Management Committee (QMC) structure and through Joint Operating Committee (JOC)

meetings with subcontractors and our Service Quality Improvement Subcommittee (SQIS). These committees are part of our quality management (QM) program infrastructure and report subcontractor monitoring activities and performance metrics through the local QMC hierarchy.

For pharmaceutical initiatives regarding quality of care and service delivery, our QMC is one of our key local decision-making bodies with oversight and input from senior leaders, medical directors, pharmaceutical director and operational leads. Chaired by our chief medical officer, our QMC implements, coordinates and integrates continuous quality improvement (CQI) activities. The QMC:

- Recommends policy decisions
- Reviews Provider engagement in our Quality Management and Performance Improvement (QMPI) programs
- Institutes actions and confirms follow-up and resolution of any open items

Our QMC oversees our MAC, Provider Advisory Committee, Medical Technology Assessment Committee, Healthcare Quality and Utilization Management Committee and SQIS and makes sure our subcontractor relationship owners (i.e., our pharmaceutical director) host and lead JOC meetings with OptumRx to evaluate their performance and make decisions regarding process and program improvement opportunities and initiatives. Using key performance indicators (KPIs) and data collected, our pharmaceutical director has a critical role in sharing information, improving health outcomes and informing program initiatives. Minutes and outcomes from QMC meetings are available for our State partners to review.

Innovative Clinical Initiatives Implemented Within the Past 36 Months

We provide three examples of data-driven clinical initiatives we introduced in Kansas and affiliate Medicaid markets that led to improved health outcomes or access to care:

- Genoa pharmacist intervention upon identifying medication nonadherence
- Nursing Facility High Risk Diversion program
- Telehealth pharmacy hubs

Example 1: Genoa Pharmacist Intervention Due to Medication Nonadherence

Genoa Healthcare (Genoa). Genoa is the largest provider of behavioral health pharmacy and clinical services for individuals with behavioral health, substance use disorder or chronic health conditions in the U.S., and we can confirm that Genoa's performance quality is no less than if our Kansas Medicaid health plan performed the services in-house. Genoa is equally held to contractual performance standards and subject to performance monitoring and oversight activities. In Kansas, Genoa operates pharmacies embedded within 13 locations consisting of community mental health centers (CMHCs) or counseling facilities. Genoa is an affiliate subcontractor UnitedHealth Group acquired in 2018.

Genoa adherence initiative. Treatment of chronic illness commonly includes long-term use of multiple medications. When a person with behavioral health conditions or chronic illness does not take their medications as prescribed, they put their health at risk or mitigate the healing effects of the other medications they take. To address this concern, we introduced our Genoa adherence initiative in Kansas in 2021.

We use weekly claims data to identify KanCare Members who are not adhering to their medication regimen or at risk of nonadherence. Genoa clinical pharmacists contact identified Members to address the nonadherence. In most cases this is a one-time, telephonic conversation with the Member to find out how they are taking their medications and if they are experiencing side effects. Once the Genoa pharmacist understands the Member's perspective, they work with the prescriber(s) to find alternatives and facilitate access to those medications to support the Member's health and well-being.

How Success of the Genoa Adherence Program is Measured

We monitor claims and utilization data for 90 days after the intervention to confirm the Member maintained adherence. If the Member is nonadherent at any point during this 90-day time frame, we continue to monitor their claims and the clinical pharmacist may conduct additional interventions depending on the Member's unique situation. For those Members who adhere to the clinical pharmacist's recommendations, we see favorable results in terms of lower hospital admissions. For example, when comparing outcomes of Members receiving intervention in the first half of 2023 versus Members we attempted to reach but could not:

- 3.7% had a behavioral health inpatient admission within 90 days of the intervention, compared to 18.8% of Members we could not reach
- 73.7% were adherent to their medication regimen within 90 days of our intervention, compared to 43.8% of Members we could not reach
- 66.7% kept their behavioral health outpatient appointment within 90 days of program enrollment, compared to 59% of Members we could not reach

This outcomes data demonstrates the Genoa Adherence program's effectiveness in improving clinical outcomes for our Members diagnosed with behavioral health conditions. We continue to track progress and monitor outcomes data to gain insights and find opportunities to increase enrollment in the program. Because of the program's positive impact on our Members' health and well-being and because of the cost savings generated, we will continue to provide this intervention for our Members. We continue to track progress and Member actions post intervention to apply lessons learned and find ways to make meaningful program improvements.

Example 2: Nursing Facility High Risk Diversion Program

[redacted]

Rebecca: A Nursing Home Diversion Success in Kansas

Situation: KanCare Member, Rebecca, was enrolled in our NFHRD program to help maintain her quality of life at home and prevent a move to nursing facility (NF) level of care. During rounds, the interdisciplinary team noted that Rebecca had experienced multiple hospitalizations due to COPD exacerbations. The clinical pharmacist assigned to the NFHRD interdisciplinary team reviewed Rebecca's pharmacy claims, which showed Rebecca had not recently filled her controller medications. Spiriva had not been filled in five months, and Symbicort had not been filled in eight months. The clinical pharmacist also noted that Rebecca's PCP tried to prescribe a triple acting inhaler the month prior, but it was not on the PDL and the prior authorization request was denied.

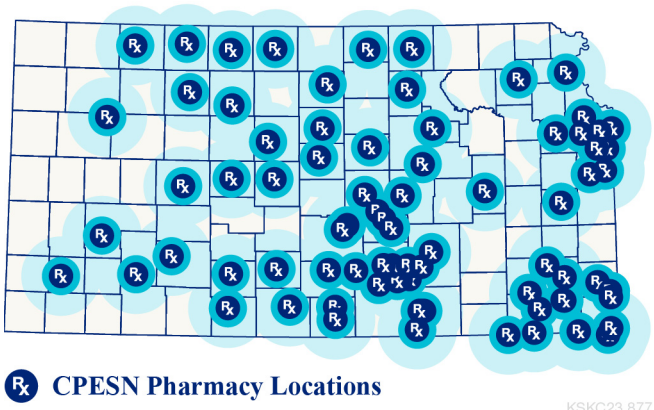
Intervention: The clinical pharmacist called Rebecca's PCP and discussed with the nurse that Trelegy was a preferred option and would not require any further paperwork from the PCP office. Rebecca's claims were monitored until the new Trelegy prescription was sent to the pharmacy. The clinical pharmacist then contacted Rebecca to educate her on her new inhaler, including how to administer it, and explained that it replaced both Spiriva and Symbicort. Our pharmacist discussed her albuterol rescue inhaler to make sure she knew how to use it and when to contact her PCP with issues before they worsen.

Outcome: Since the intervention, Rebecca has not returned to the hospital and has not required NF level of care.

Example 3: Telehealth Pharmacy Hubs

[redacted]

Figure 14-2. Kansas Telehealth Pharmacy Hubs



[redacted]

[redacted]

Virginia Telehealth Pharmacy Hub Member Experience

Situation: A 58-year-old Member had had a stroke before his recent incarceration. As he was preparing for release, he had a challenging time getting an appointment with a doctor so he could get his prescriptions filled.
Intervention: We arranged for telehealth service at the pharmacy hub and were able to get him on appropriate post-stroke care, start a smoking cessation program and get refills on his medications that were due to expire.
Outcome: After using the telehealth pharmacy hub, the Member exclaimed that he had "never seen a pharmacy like us before" and expressed immense gratitude to the pharmacy technician for helping him get back on track.

Summary

To integrate pharmacy services systemically, we harness real-time and near real-time data to design, implement and evaluate clinical programs and best practices. Pharmacy data gives our clinical care teams and Providers a view into the Member's past and current medical history to make informed decisions about medications and treatment plans in collaboration with the Member's Providers. Our interdisciplinary teams use this data and incorporate it into clinical care notes for their ongoing Member engagement activities. As part of our ongoing risk stratification, quality, utilization management and reporting activities, we apply a scientific, evidence-based process to gather pharmacy data and combine it with other data sources, such as clinical claims from inpatient and outpatient settings, lab services and nonclinical sources such as SDOH. This enables our pharmacy, clinical care and care coordination teams to gain meaningful insights that can be used to improve the health of the people they serve.

Utilization Management and Services

15. Describe the bidder's approach to ensuring KanCare Members, including Members residing in Rural and frontier areas of the State, receive non-emergency medical transportation (NEMT) services in accordance with the Access standards in Section 7.5.5.5 of the RFP.

Ensuring Members Receive Nonemergency Medical Transportation Services

With over 10 years of experience serving KanCare Members, we have provided over 2 million rides and nearly 471,000 miles in mileage reimbursement. In addition, we have arranged nearly 11,000 lodging days and over 6,000 meals for our KanCare Members needing overnight or out-of-town transport. Our comprehensive approach to making sure Members receive needed nonemergency medical transportation (NEMT) care encompasses these priorities:

- **Confirming** transportation access with focus on Kansas' frontier and rural counties
- **Continuously** improving the Member experience using feedback from multiple sources
- **Monitoring** and measuring transportation service quality as part of our ongoing quality improvement activities

With this approach, we facilitate Members' timely access to care and services. Modivcare Solutions, LLC has been our nonaffiliate NEMT subcontractor since 2013. We work closely with Modivcare and community-based organizations and our care coordination teams to facilitate access and find new avenues for the provision of NEMT services, such as our partnerships with Johnson County Mental Health Center, federally qualified health centers (FQHCs) and rural health centers (RHCs). For the KanCare Capitated Managed Care contract, UnitedHealthcare will comply with the access standards listed in RFP **Scope of Services 7.5.5.5**, including subparts A through L.

Our experience, outcomes data and understanding of available transportation resources and Member use patterns across all 105 counties in Kansas drives how we manage the provision of NEMT services for our KanCare Members. In urban areas, where ride demand is highest, we closely monitor driver capacity to confirm sufficient transportation providers are available to meet day-to-day demands. In rural and frontier regions, we focus on maintaining adequate coverage in partnership with Modivcare. For instance, in 2022, we increased the mileage reimbursement rate and included volunteer drivers in the program. This change has been well-received by our Members who use volunteer drivers. Through our value-added benefits (VABs), we cover rides to locations promoting health equity and address SDOH, including grocery stores, churches, food banks, Women, Infants and Children (WIC) services, schools, job fairs, job interviews and community events.

Recognizing NEMT is vital to health care delivery for Medicaid populations, we prioritize ongoing oversight of NEMT access and quality. With our continued Member outreach, education efforts and VABs, we are increasing the number of trips provided each year. Our dedicated local team includes our vendor oversight manager, Christine Vandegrift, who serves as our dedicated transportation program manager and as the primary liaison for performance, quality and contract compliance with Modivcare.

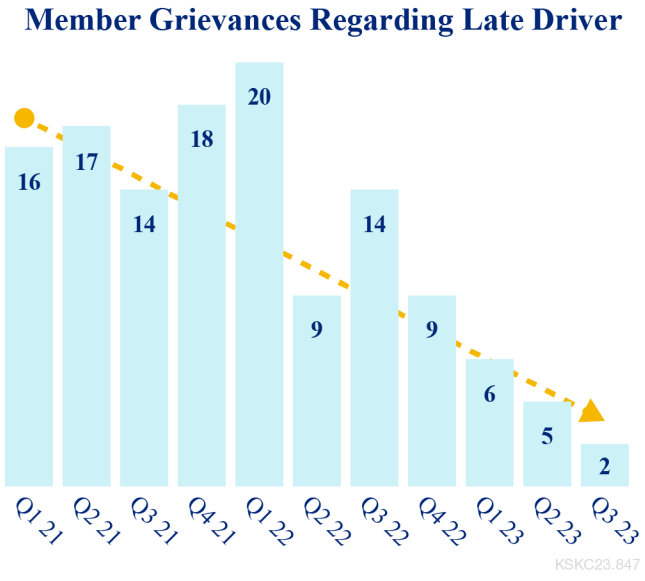
Confirming Transportation Access on Frontier and Rural Counties

With our experience in Kansas, we have a dynamic, statewide transportation network. Nevertheless, we continually monitor network adequacy in all 105 Kansas counties and have focused on frontier and rural areas over the past three years to increase network size. To maintain transportation network adequacy, we gather information from multiple sources, such as data analyses and audits, feedback from Members via surveys, our Member Advisory Committee (MAC), grievance trends, call center staff and managers and other outcomes reports. We use the data collectively to gain insight into areas for targeted provider recruiting.

Through targeted recruiting, we improved network access in frontier and rural areas with the network inclusion of volunteer drivers, FQHCs and RHCs that provide transportation. Where available, appropriate, and as a last resort, we allow Members to use rideshare services. Through our ongoing education and outreach activities, we educate Members, Providers, community-based organizations and our member services and care coordination staff about these enhancements to promote and increase use of these services.

Confirming transportation providers arrive on time for pickups is a critical area of focus for us. We aim to drop members off at their appointments no earlier than an hour before their scheduled time and at least 15 minutes prior to their appointment. We closely monitor wait times to confirm Members do not have to wait for more than an hour after their appointment for their return trip. Our efforts in monitoring and increasing oversight have yielded significant results. As depicted in the figure, there has been a notable decrease in Grievances regarding late drivers from January 2021 through the third quarter of 2023. To achieve these results, we held frequent oversight meetings with Modivcare, closely reviewing performance of individual providers. We took proactive measures to address and resolve performance with drivers who were unable to meet their contractual obligations, confirming our Members receive reliable transportation services.

Figure 15-1. Late Driver Member Grievances



We bolstered the network in frontier and rural areas of Kansas by contracting with new Providers, such as Community Health Center of Southeast Kansas and other FQHCs and RHCs in Kansas. This strategic approach enabled us to enhance the quality of our transportation network and better serve our Members' needs, particularly in rural and frontier areas.

To facilitate timely access to NEMT services whether a Member lives in a rural, frontier or urban part of Kansas or has special mobility or medical needs, we contractually require Modivcare to follow an established process for trip intake and scheduling. We have dedicated staff who collaborate with Modivcare staff to make sure Members' needs are considered so the right driver and right form of transportation is provided at the right time.

Exception Requests and Authorizations

When medical appointments are a long distance from a Member's home, it often creates a need for an overnight stay or meals. For these scenarios, we follow our exception request authorization process. When a Member needs additional services tied to their trip and medical appointment, our dedicated vendor oversight manager leads the exception process. When a Member needs additional services not provided through Modivcare's network, such as lodging, food or air travel, Modivcare submits an exception request to our vendor oversight manager. Our vendor oversight manager responds to exception requests within one business day of receipt.

Our dedicated member experience coordinator, Maria Weiler, is always ready to step in and provide personalized assistance when complex or unique scenarios arise, no matter the time required to find a solution. In these escalated scenarios, she works closely with Members and their families to find the most suitable solution for their specific health care needs, updating our vendor oversight manager of progress. One such instance involved a young girl in need of urgent dental care from a Provider located far away. Ms. Weiler went above and beyond by coordinating the exception request process and partnering with the family to arrange lodging, transportation and locate a dental provider who could meet the unique health care requirements of our member. In situations like these, Ms. Weiler's expertise and compassionate support enable us to meet our Members' needs in the most efficient and effective manner possible.

Improving the Member Experience Using Feedback from Multiple Sources

As part of our ongoing efforts to improve the Member experience, we seek Member feedback via formal and ad hoc surveys, document and address grievances, provide training for our staff, publicize improvements through awareness campaigns and improve the ease of scheduling and tracking rides. With a continuous improvement focus, we use information we collect to develop and enhance workflows and communication for improved quality delivery for our Members.

Seeking Member Feedback

Through various channels, we make it a priority to gather feedback from our KanCare Members regarding NEMT services. We hold listening tours throughout Kansas and receive input and valuable insights from our MAC and Members. Our dedicated member advocates and care coordination teams work closely with Members to address their NEMT needs and share any concerns about a Member's unique situation with our vendor oversight manager. This direct feedback enables us to address those concerns immediately and to capture these issues in our trending reports where we can identify systemic opportunities for improvement. To further gauge Member satisfaction, we meet with our MAC quarterly to gather feedback on our programs and benefits, including NEMT services. Our dedicated vendor oversight manager oversees follow-up on any ideas or issues brought forth during these sessions. Based on feedback from Members and the MAC received in 2021, we increased mileage reimbursement rates and expanded scheduling options. Further, we introduced time-saving alternatives to transportation such as telehealth.

Responding to Member Feedback

Listening to our Members' concerns about rising gas prices and limited transportation services in frontier and rural counties, we improved our mileage reimbursement program with:

- **Easier Reimbursement Process** – In addition to fax and email options for submitting trip logs for reimbursement, Members can use a mobile app to submit trip logs for real-time trip submission, which leads to shorter reimbursement turnaround times.

- **Increased Per Mile Rate** – In 2022, we increased our mileage reimbursement rate from $0.40 to $0.50 per mile, resulting in over 13,400 more mileage reimbursement trips from the first quarter of 2022 through the third quarter of 2023.

If a Member needs extra assistance with setting up transportation, in addition to Modivcare, their case manager, care coordinator or any one of our member advocates assist them with scheduling rides. Our teams interacting directly with Members have access to and have been trained on how to assist Members in managing trips. We learned from our care coordination teams that this approach has been particularly helpful to some of our Members with a brain injury who sometimes find managing trip requests in addition to doctor appointments overwhelming.

Also, in response to Member and MAC feedback, we expanded the provision of NEMT services to meet the transportation access needs of certain populations or to remove barriers to other services Members receive from the State or in the community. For example, we added two VABs for transportation. These are the Enhanced Transportation Support VAB enabling Members to have up to 24 round-trip rides per year for easier access to community-based support services addressing SDOH, and the Bus Passes VAB that gives Members who have access to nearby public transportation services up to $25 in bus passes per year. We transformed the Johnson County pilot program into a permanent approach. The Johnson County initiative was so successful in advancing health equity that it became a model for providing transportation services for individuals working toward independence and employment.

Documenting and Addressing Member Grievances

We view Grievances as a type of feedback and an opportunity to improve our NEMT program. Members who share Grievances about their NEMT experience with any member of our team have their concern documented and addressed as a grievance. We oversee the NEMT Grievance resolution and reporting process to confirm Modivcare provides consistent, high-quality service to our Members. For example, Member Grievances about not being able to know when the driver would arrive was a driving factor in adding Modivcare's digital tool to enable Members to schedule and manage trips through mobile devices. By holding ourselves and Modivcare

Johnson County Innovation Transforms into a Peer Support Best Practice

Situation: In collaboration with Johnson County Mental Health Center (JCMHC), we launched a pilot program to support wraparound transportation as part of our KanCare Members' rehabilitation journey. Initially, our goal was to test whether wraparound transportation would improve outcomes for our Members who JCMHC serves.

Intervention: Within the first six months of initiation, we discovered that Members whose rehabilitation treatment plan included getting and keeping a job had the highest adherence rates due to the transportation support they received. With this understanding, we redirected our approach whereby community service workers at JCMHC refer our Members for peer support that includes transportation to and from work. We train the peers and pay them for providing the transportation. The peers give feedback to care coordinators to help in the reentry to work experience for our KanCare Members.

Outcome: Peer supports transport 30 to 35 Members to and from work each week. About 85% of Members who receive this support "graduate" from JCMHC's program with income to acquire a vehicle and stay employed.

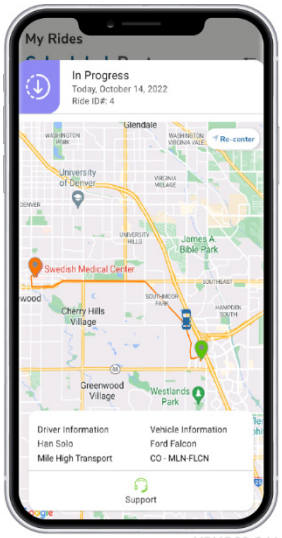
Public Recognition: This program's success in advancing health equity has been recognized in the media, by the State of Kansas and the Disability Rights Council. To show their appreciation, Johnson County officials named the program after founder, Corey Stoltz, whose work has profoundly impacted the quality of life for the people of Johnson County.

accountable for improving the Member experience, we achieved measurable improvements in Member satisfaction with NEMT services.

Easing the Ride Scheduling and Tracking Experience for Members

UnitedHealthcare also uses national feedback to inform our NEMT offering. Based on input from our national member advisory board (a board made up of members and member advocacy organizations) and our national data we believe that roughly 95% of members have a smartphone and 61% prefer to use their smartphone to access their benefits, such as scheduling doctor visits. Modivcare responded to an increase in digital demand by offering Members new mobile app capabilities to improve the Member experience. Through Modivcare's enhanced digital experience, KanCare Members have:

Figure 15-2. Modivcare App



- **Ease of scheduling with online tools and apps** – In addition to calling, Members can use other options for ride scheduling using online tools and apps. Modivcare offers a user-friendly app with training videos for first-time users. The app allows Members to make and manage trip reservations. Our outreach staff receives training on how to use the online tools and apps so they can show Members how to use them. To further improve the Member experience, Modivcare successfully implemented a new platform, Genesis Cloud CX®, which streamlines the trip request process and has a machine learning capability to match Members with drivers with the highest performance ratings.
- **Driver tracking capabilities** – As shown in the figure, Members who use Modivcare's mobile app can view driver-in-route location and get updates on arrival times in real time. Call center representatives can view the real-time tracking as well, which enables them to assist Members who have questions or concerns about the driver's arrival. This tracking technology allows us to monitor Modivcare's dispatching and driver activities to confirm routes are efficient and do not include unnecessary stops.
- **Care Manager and Care Coordinator Assistance** – With Member consent, we give our case managers and care coordinators access to the Member's NEMT records using single sign-on access credentials. With this capability, they can schedule and manage trips on behalf of the Members they serve. This is especially popular with our teams who work with Members who have serious mental illness, traumatic brain injuries or receive long-term services and supports. At times, these Members have questions or need reassurance the trip is set up correctly. This capability allows our team to bypass the call center and get answers directly from the Member's NEMT record. If a Member has recurring appointments for services such as dialysis treatment, individuals at the clinic can set up recurring trips on the Member's behalf using the online tool or call center.

To further facilitate ease and convenience in requesting and scheduling NEMT, these options are available to Members and Providers 24 hours a day, seven days a week.

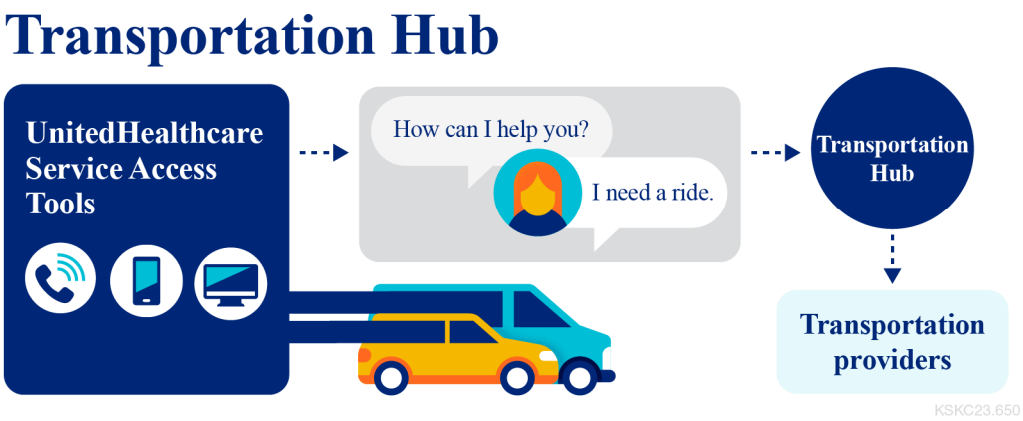
UnitedHealthcare Mobile App

As of December 2023, our mobile app is **ranked number two of all medical apps** within the Apple App Store and has been reviewed over 227,000 times, receiving 4.7 stars out of five.

Transportation Hub

In addition to the call center, online services or Modivcare's mobile app, in 2024, Members will have a new scheduling option — UnitedHealthcare's Transportation Hub. With it, Members can access their NEMT benefits through our popular mobile app, creating a one-stop-shop where they can schedule doctor appointments and transportation at the same time and within the same digital location. We do not require Members to use external applications or websites to get to the hub, which adds to its efficiency.

Figure 15-3. Transportation Hub



As shown in the figure, Members can use their smartphone or other devices to get to Transportation Hub's singular landing page on our website (*myuhc.com*), our Member portal or our mobile app. From there, Members have user-friendly options to schedule doctor appointments and transportation. Members can chat with a member services advocate (in English or Spanish) for assistance. Providing Members with options like these is in part why **UnitedHealthcare's digital engagement surged by 295%, mobile app logins increased by 533%, and Member satisfaction rose nearly 30% year-to-date.**

Standing Orders

When a Member needs recurring trips scheduled over an extended time, we coordinate with the facility or Provider site where the Member receives care. For example, Members who receive dialysis or chemotherapy treatments have standing orders where they or the personnel at the treatment facility can book trips on behalf of the Member up to six months in advance.

To facilitate Member-centered care for our Members with recurring trips and special needs, we require Modivcare to prioritize Member choice in pairing of a Member with the same driver and the appropriate vehicle type to safely transport the Member. When the Member and driver are familiar with each other, it improves the overall service experience. With the same driver for every trip, the Member gains a sense of reliance on the driver, which quells the anxiety change or newness can cause and makes the ride more enjoyable.

Monitoring and Measuring Transportation Service Quality

Parallel to ongoing performance improvement activities, we maintain consistency in our transportation quality oversight approach through our ongoing oversight, monitoring and reporting approach. This approach keeps us accountable and Modivcare on track to meet the State's transportation access standards and deliver high-quality transportation services to our Members.

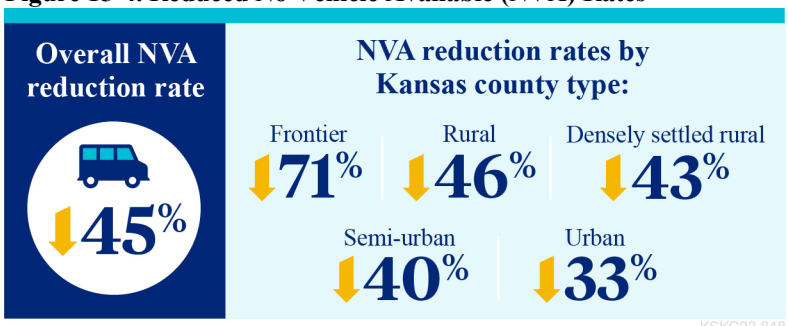
Modivcare is held to contract performance standards and subject to performance monitoring and oversight activities. Subcontractor oversight activities are integrated within our QMC structure.

Our vendor oversight manager oversees the evaluation process for Modivcare, and we will comply with the standards described in **Scope of Services 7.5.5.5**, subpart G regarding performance auditing protocol and including claims accuracy and payment integrity. In 2021, we enhanced our performance auditing protocol to include quarterly performance audits in addition to an annual audit. Previously, we performed only the annual audit. This rigorous protocol enables both Modivcare and us to deliver a better customer service experience to our Members, Providers, the State and stakeholders.

UnitedHealthcare and Modivcare will comply with **Scope of Services 7.5.5.5** subpart A and B regarding arrival and wait time requirements at the Member's pickup location, subpart C and D regarding arrival and wait times at the drop-off site, and subpart F regarding return rides using the most efficient routes. Our additional oversight focuses on measuring service quality using key metrics and goals compared to outcomes data to find root causes and inform our ongoing transportation quality improvement initiatives. Tactically, we:

- **Increased meeting cadence** – To quickly identify and address issues, we increased meeting frequency with Modivcare from quarterly JOC reviews.
  - At weekly meetings, we review key performance metrics, such as no-shows, no vehicles available, call center performance and on-time pick up and arrival; review network status and share leads for new transportation providers; and follow up on items discussed in previous meetings.
  - At monthly meetings, we review grievance reports to spot risk and trends and to find root causes; receiving updates on quality improvement initiatives based on previously identified trends.
- **Improved administrative functions** – Stronger oversight of Modivcare's performance and reporting activities. As we worked to get back to normal after the pandemic, NEMT was especially affected in terms of finding drivers serving rural and frontier areas of Kansas. To improve performance, we worked with Modivcare in the following areas:
  - *Data integrity* – We discovered inconsistencies in how certain metrics were calculated, such as missed appointments, which were corrected with our increased monitoring and oversight activities.
  - *Network development* – We found opportunities to use membership distribution data more effectively to understand transportation network needs by county. As shown in Figure **15-4**, No Vehicle Available (NVA) **rates decreased significantly throughout Kansas**, reducing the statewide metric NVA by 45% over the previous 18 months.

Figure 15-4. Reduced No Vehicle Available (NVA) Rates

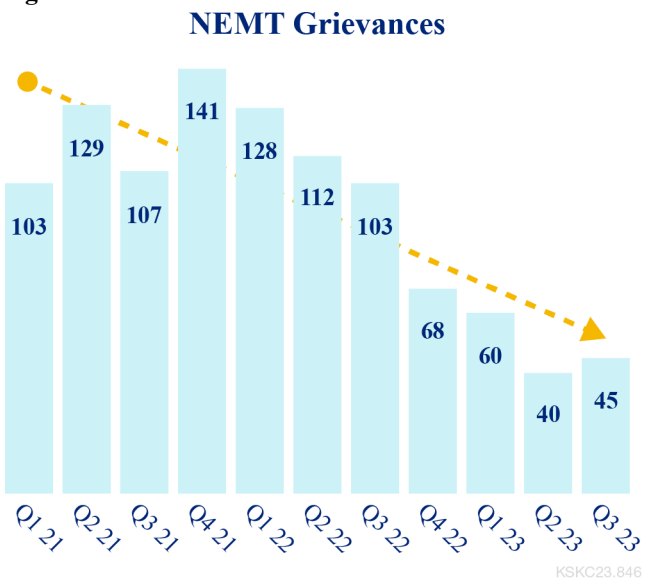


  - *Call center staff training* – To improve the Member experience, we established a monthly process known as "call calibration" whereby our call center and vendor oversight manager and Modivcare's call center managers listen in on calls to find

opportunities for retraining or to improve our training curriculum. Also, call calibrations help call center managers to quickly address issues, resulting in fewer Grievances and increased awareness of the NEMT benefit options for scheduling and tracking rides.

As shown in the figure, due to our oversight activities, we have seen a steady reduction in Member Grievances about NEMT. Of note, Modivcare's new platform has a performance dashboard giving drivers a tool to help them to be more accountable and aware of dispatch and driver performance "in the moment" so they can quickly address performance issues revealed by the dashboard. Modivcare trained drivers in their network on how to use the dashboard for day-to-day activities. When a driver's performance does not meet standards, we require Modivcare to address the performance issue. Depending on severity, remediation activities could include corrective actions or reducing trip assignments until the driver is compliant.

Figure 15-5. Reduced NEMT Grievances



Internal Staff and Modivcare Driver and Dispatcher Training

Through direct interaction and at training sessions, meetings or community events, our Member, Provider and community outreach staff educate Members about their NEMT benefit and how to access it. We provide training specific to transportation services for our member service advocates and care coordinators to make sure they are aware of program enhancements and know how to assist Members in obtaining the service (i.e., value-added benefit or new way to schedule NEMT). We require Modivcare to train drivers and dispatchers on the importance of:

- Reminding Members to request transportation at least three calendar days before their appointment when the appointment is not urgent
- Scheduling transportation to urgent care facilities or for same-day appointments that are medically necessary within three hours of the trip request
- Adhering to our guidelines and coordinating timely facility-to-facility transfers and pickups (i.e., facility discharges) within three hours of the trip request and in close communication with the Member's care coordinator, a designated person at the facility and the Member

We require Modivcare to include in their training curriculum pickup and drop-off timeliness, how to communicate and interact with Members before, during and after the trip, and when and how to report incidents or unanticipated situations.

Utilization Management and Services

16. Describe the bidder's proposed array of Behavioral Health crisis services and how those services will interface with 988 and other crisis resources within Kansas. Include the following in the bidder's response:

UnitedHealthcare's Proposed Array of Behavioral Health Crisis Services

At UnitedHealthcare, we are committed to providing comprehensive behavioral health (BH) crisis services to Kansans to support the State's overall crisis system to help mitigate the growing problem of crisis events and deaths in Kansas. According to the CDC, in 2021, Kansas had the second largest percentage increase in drug overdose deaths, nationally, and, in 2022, suicide was the leading cause of death among Kansans aged 15 to 25 and the second leading cause of death for ages 25 to 44. We have a threefold strategy for the provision of BH crisis services to **drive overall improvement** in the statewide crisis system and make sure vulnerable Members, and Members in distress, receive the services they need.

- **Build the capacity of the BH crisis system** through workforce development, community investments, reducing Provider administrative burden and supporting Providers with education and training.
- **Collaborate with and invest in community Providers, first responders and law enforcement** to support a consistent and uniform approach to managing Members in crisis.
- **Use evidence-based practices tailored to the unique needs of our Members across Kansas**, including subpopulations such as rural and frontier, school-based youth, LGBTQ+, individuals with intellectual and developmental disabilities, older adults, and Black, Indigenous and People of Color (BIPOC) which ensures services provided are relevant and address the specific needs of all Members.

These strategies are driving results for KanCare Members. As of November 2023, we observed a 4% increase in the number of Members using crisis services (comparing Q1 and Q2 2023 to the same period in 2022) while simultaneously seeing a decrease in total crisis utilization — a 13.2% decrease in inpatient days per 1,000 and a 14.3% decrease in average length of stay (ALOS). This indicates Members are accessing crisis services earlier, thereby reducing crisis escalation.

a. The bidder's approach to collaborating with its Behavioral Health crisis Providers, first responders, and other crisis resources to create a comprehensive, well-coordinated, Behavioral Health crisis continuum for all Members.

Collaborative Approach to Creating a Comprehensive, Well-Coordinated Behavioral Health Crisis Continuum

We have designed, developed and funded crisis systems with 22 state Medicaid, BH carve-out and D-SNP programs and coordinated care with mobile crisis team Providers and law enforcement agencies in 16 states, including Kansas. As described in detail herein and depicted in the figure, our strategies for creating a comprehensive, well-coordinated, BH crisis continuum for all Members are rooted in collaboration with Providers and first responders, and partnering with Community Mental Health Centers (CMHCs) and Certified Community Behavioral Health Clinics (CCBHCs) and other stakeholders in three main components along the crisis continuum:

(1) Prevention and Early Intervention, (2) Crisis Response and Stabilization and (3) Follow-Up and Ongoing Care. All our efforts are grounded in the Zero Suicide framework, which provides an evidence-based framework for system-wide transformation toward safer Member care.

Figure 16-1. Our Crisis Continuum

Prevention and Early Intervention

Our prevention and early intervention efforts focus on (1) raising awareness, (2) helping Providers and communities build the skills to prevent, recognize and respond to crisis, and (3) providing Members with the resources needed to support themselves and their families.

Collaborative Efforts to Raise Awareness

We collaborate with community organizations, Providers, CMHCs/CCBHCs and first responders to raise awareness about helping Kansans through crisis. Our Kansas-based recovery & resiliency (R&R) State lead, a certified peer support specialist (CPSS), provides free trainings in the community on evidence-based practices, such as Mental Health First Aid (MHFA), Seeking Safety and Question, Persuade, Refer (QPR), to educate individuals, Providers and communities on how to recognize the impact of mental health and substance use disorders (SUDs), understand and respond to signs of a crisis and support individuals who may need additional help. Since 2019, we have hosted over 100 R&R trainings throughout Kansas in both English and Spanish and reached over 1,000 participants.

Member Quote on Seeking Safety

"I am a 62-year-old man who has hated himself vehemently all his life. Seeking Safety has given me a place to know I am not alone, new tools and creative ways to feeling safe with no limits and empowered lifestyle changes, along with the leadership from Rhonda with respect, empathy, and agape love."

Collaborating to Enable Providers and Community Agencies

We support Providers of all backgrounds (e.g., CMHCs/CCBHCs, PCPs, BH Providers, specialists) with trainings, tools and resources to help build and sharpen the skills necessary to identify early signs of crisis, enabling them to respond promptly and appropriately before situations escalate. These trainings, tools and resources are available on our Provider portal, we publish information about them in Provider newsletters, and our provider enablement consultants (PEC) and Clinical Practice Consultants educate Providers on how to access these valuable resources, which include:

- **Provider Toolkits:** We offer a variety of toolkits to support and guide Providers through critical topics, including the Suicide Prevention Toolkit for PCPs, and Recovery and Resiliency Empowerment Toolkit, both of which highlight 988.
- **OptumHealth Education™:** Offers accredited, on-demand, free Continuing Medical Education and Continuing Education Units (CEU) to Providers, including a variety of trainings, such as the Mental Health Crisis in Adolescents: Expanding Current Capabilities to Meet Surging Needs, to help them treat Members at risk for crisis, showing warning signs of crises and post-crisis. **Since 2021, Kansas Providers completed over 1,700 courses and received over 2,245 CEU credits.**

- **Psych Hub:** To help prepare Providers for areas outside their normal practice, we will offer 200 free Provider licenses to Psych Hub in Kansas beginning in 2024. Psych Hub is offering an Adolescent Treatment Series and a Suicide Prevention Series.

Member Supports and Resources

Our efforts put our Members – our neighbors – first and focus on empowering individuals to thrive. Member supports are person-centered and tailored to unique individual needs. Through the Health and Wellness Hub on the *myuhc.com* Member portal, Members can access a variety of resources around crisis support, prevention, response and caring for loved ones. Easy-to-use resources such as the Wellness Wheel Toolkit and Whole Health Tracker help Members identify their goals, interventions and ways to self-manage their health, and help them create a complete picture of their progress in their wellness journey. Value-added benefits such as Pyx Health and Self Care help provide digital support to help Members address social isolation, depression and anxiety. All Member-facing staff, including Member services and care coordination, are trained in trauma-informed care, and all field-based care coordination staff receive QPR training.

Increasing Narcan Access

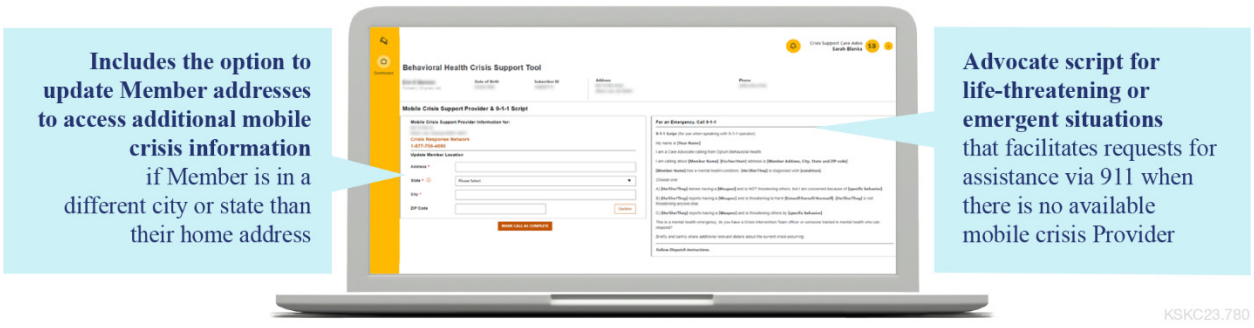
We are investing $50,000 in Narcan distribution in rural counties in Western Kansas through Livewell Finney County, an Opioid Taskforce and Health Coalition, to bring opioid overdose prevention and response to rural areas of the State.

Crisis Response and Stabilization

We collaborate with crisis stakeholders throughout Kansas, including CMHCs/CCBHCs, BH crisis Providers and first responders, to provide a "No Wrong Door" approach for Members in crisis. We promote the use of 988 on our Member and Provider portals and train all Member-facing staff on the appropriate uses of 988 and 911, identifying Members in crisis and providing crisis support, which helps relieve pressure on law enforcement and first responders. Our 24 hours a day, seven days a week BH Crisis Support Line provides access to licensed BH clinicians to triage Members experiencing a BH crisis. We use comprehensive and specialized screening tools for risk assessment and Member safety, including screening for those who threaten self-harm (e.g., health risk assessments (HRA) and PHQ-9 for depression, suicide and self-harm).

In addition, we integrated a **Crisis Support Tool** into our care management system, CommunityCare, which engages crisis services in real time, dispatching a local mobile crisis unit to the Member's location and relieving pressure within the 911 emergency and 988 crisis systems. Nationally, from January through October 2023, 358 Members received mobile crisis services because of care coordination staff using the Crisis Support Tool, and as a result, **63% avoided inpatient and emergency department (ED) stays in the seven days following** their mobile crisis dispatches.

Figure 16-2. UnitedHealthcare's Crisis Support Tool



Building Infrastructure and Capacity

In support of the Kansas BHS Commission 2023 – 2027 objective to continue to build out mobile crisis and crisis stabilization services for statewide coverage 24 hours a day, seven days a week, we commit to partnering with BH Providers and first responders to build infrastructure and capacity. Our innovative solutions include but are not limited to:

Initiative	Innovative Solutions
Expand Crisis Network	We are contracted with 100% of the mobile crisis and crisis stabilization Providers in Kansas and commit to continued contracting with these Providers as capacity grows, aiming to include all high-quality Providers in our network.
Develop Co-responder Model	As we explore bringing a co-responder model to Kansas, we will use our experience in Tennessee where the program's outcomes included reduction in ED visits and hospitalizations, with 60% of TennCare patients treated using this model being diverted from EDs. To reduce burden on law enforcement and first responders, the model uses a multidisciplinary team to address BH crisis emergencies and creates an environment where services can be rendered and billed for within the community. We commit to partnering with Kansas stakeholders (e.g., KDHE, KDADS, CMS, MCOs, Vibrant) to explore development of a sustainable interdisciplinary co-responder model that supports stabilization and care coordination for Kansans experiencing a BH crisis.
Support and Equip First Responders	In 2024, we will partner with first responders to train communities on Narcan administration. We will also partner with a local CMHC/CCBHC to host a First Responder Wellness Day and deploy MHFA for first responders to equip them with the supports necessary to respond to BH crises and to focus on their wellness and resiliency given the unique mental and physical risks of their jobs.

Follow-up and Ongoing Care

Follow-up after a crisis episode is a critical part of supporting individuals through the crisis continuum; the sooner we provide treatment and stabilization to a Member in crisis, the greater the likelihood of an improved outcome. Our Provider network offers Members 38 Express Access BH Providers who confirm appointment availability within five days, and we maximize the use of telehealth, where appropriate, for Members who prefer receiving care at home or reside in a rural or frontier county that lacks resources or available Providers. We emphasize timely follow-up for post-crisis recovery and commit to exceeding contract requirements by following up within 48 hours of notification with all our Members who received crisis services during a crisis episode.

We will leverage our Crisis Consolidator tool, which aggregates crisis call center data, call disposition, mobile team response and follow-up status for our Members, and by partnering with 988 Providers and first responders to identify Members for follow-up services. We will also use this outreach to address ongoing needs, such as connecting Members with a CPSS to support recovery. To improve notification of crisis episodes, we have initiated conversations with the 988 vendors and commit to building upon existing stakeholders meetings by convening a workgroup, (including KDHE, KDADS, other state agencies and MCOs) to develop streamlined, consistent data-sharing capabilities to enable timelier follow-up after all crisis events. We have used our Crisis Data Consolidator tool successfully in other states. **For example, in 2022, this tool led to more than 8,200 Member crisis follow-up outreach calls by our staff.** We anticipate we can achieve similar results in Kansas.

Care Coordination Support

We coordinate care by linking Members to Providers, services and community resources post-crisis to promote stabilization. Our compassionate and personalized care coordination approach is amplified by network Providers, innovative supports and statewide care coordination team:

- In 2020, we implemented our **Reducing Admissions through Collaborative Interventions** (RACI) program in Kansas, wrapping interdisciplinary supports around high needs Members in higher levels of care. This program targets successful discharge, community tenure and connection to community supports and crisis interventions. Since October 2020, Members enrolled in our RACI program who receive care at [redacted]
- In 2024, we will launch our **Whole Health Engagement** (WHE) program in Kansas. WHE provides comprehensive and holistic management of Members diagnosed with serious mental illness(SMI) or SUD by using peer supports to engage members in both BH and physical health care. WHE increases use of community Providers and resources, such as crisis services, to make sure Members who might not otherwise engage in BH supports, receive care in the right setting at the right time to improve their quality of life and stability in the community. The ADT event portal allows for monitoring of Member movements, assigned staff or Accountable Entity, facility location and reason for admission.

Whole Health Engagement Results

The 2023 YTD results from our WHE program in Louisiana show improvements in 7- and 30-day follow-up after hospitalization for mental illness (FUH) and follow-up after ED visit for mental illness (FUM):

- FUH 7-day (up 6.8%)
- FUH 30-day (up 9.3%)
- FUM 7-day (up 8.5%)

b. The bidder's approach to collecting data, measuring, and evaluating the effectiveness of its Behavioral Health crisis services, and implementing improvements based on its evaluation findings.

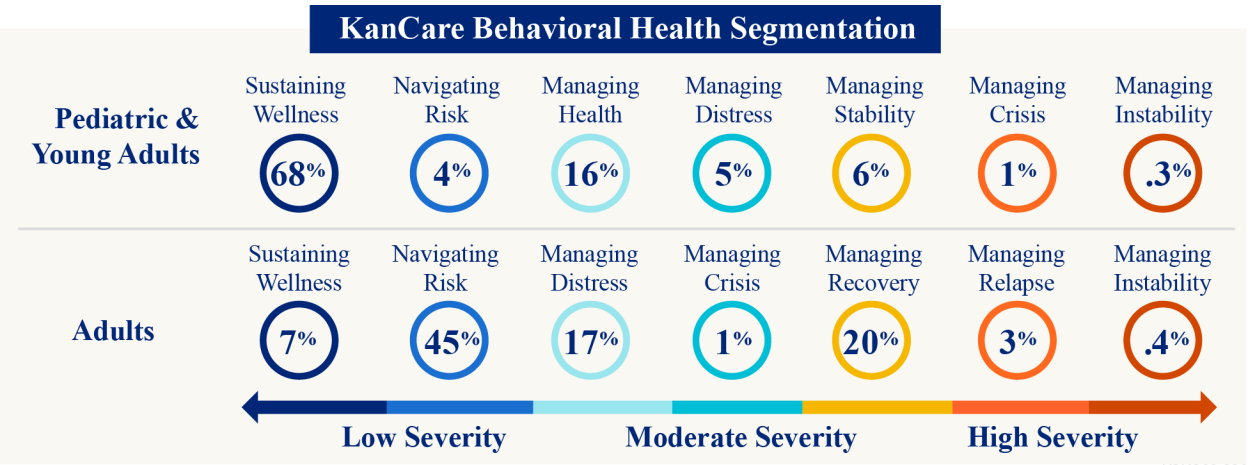
Collecting Data, Measuring and Evaluating Effectiveness of Crisis Services

Our comprehensive approach to measuring and evaluating the effectiveness of our BH crisis services is led by our BH chief medical officer and BH executive director and uses a disciplined continuous quality improvement (CQI) process that starts with comprehensive data collection efforts and a strong understanding of the data. At defined intervals, we collect quantitative and qualitative data and insights to understand Members' needs (e.g., data from 988 Providers, claims, our BH Crisis Support Line, ADT data, care coordination notes and Provider and Member surveys and feedback). Our trained staff and dedicated analytics team use advanced analytics to evaluate the effectiveness of our BH crisis services, including crisis call center metrics (e.g., number of calls transferred and handled, abandon rate, average speed to answer, call disposition), crisis services claims utilization (e.g., ALOS, subsequent ED visits, inpatient admissions and PCP visits) and Member health outcomes (e.g., mental health acuity, suicide rates, alcohol or substance use). We disaggregate all data to better understand implications related to health equity and address disparities based on available Member demographic information, including ethnicity, race, socioeconomic status, language spoken, age and geography. Analysis of Kansas crisis utilization data from 2021 to 2023 shows:

- 53.2% of utilization was for Members under age 18, boys ages 0 to 5 and 6 to 12 are three times and 1.4 times, respectively, more likely to use crisis services than girls of the same age.
- 24% of utilization was for Members aged 40 to 64, with 38% of this group having a diagnosis of schizophrenia, 30% depression and 20% bipolar disorder.
- Racial and ethnic distribution of BH crisis utilization is comparable to our overall membership distribution — e.g., Black and African American Members make up 11% of our membership and crisis utilization is 10%; American Indian and Alaska Native membership and crisis utilization are 1%.
- 34% of Members had an outpatient follow-up visit with a BH Provider within seven days of receiving BH crisis services in 2022.

Once data has been collected and verified, we use data analytics to measure the data against baselines and projections and examine the results to evaluate the effectiveness of services and interventions on the different populations served. We understand that knowing how to best serve our Members begins with knowing where our Members are on their path to wellness, and where their challenges lie. For example, analyzing adult and pediatric Member segmentation across the BH continuum of needs, including managing crisis, as shown in the figure, enables us allocate resources where needed and introduce or expand services and interventions.

Figure 16-3. KanCare Behavioral Health Member Segmentation by Stage



Implementing Improvements Based on Evaluation Findings

We use tools like Plan-Do-Study-Act cycles, Key Driver Diagrams and other best practices in CQI science to implement, monitor and evolve our approaches based on evaluation findings. We perform a root cause analysis to determine possible causes and develop strategies to address those causes and overcome the disparities. The data is further analyzed through a CQI lens to include benchmarking, evaluating positive and negative trending, establishing performance targets and developing cross-functional improvement initiatives when targets are not met, or negative trends are discovered. We include this data and findings in our Quality Assessment and Performance (QAPI) Work Plan and evaluate root causes of lagging performance for indicators that are not on track to meet targets and deploy initiatives to overcome identified barriers or inequities.

Kansas-specific Improvement – Addressing SDOH: Using 2023 BH crisis claims data, we cross-referenced Kansas crisis utilization data with SDOH needs and discovered that 15% of adults who had a crisis claim suffer from housing insecurity or homelessness. To help prevent these crisis situations, we obtained Member-specific demographics and are in the process of outreaching to the impacted Members to connect them to housing navigator support. We will closely measure and evaluate the effectiveness of this outreach and engagement and evolve our efforts accordingly. As described previously, we believe that by obtaining timelier BH crisis utilization data, including 988 call centers, we can more promptly follow-up with Members to help coordinate their care and address SDOH needs. In 2024 we will deploy use of our Crisis Consolidator Tool in Kansas to aggregate crisis call center data (ideally daily), call disposition, mobile team response and follow-up status for our Members which will further enable our ability to measure and evaluate the effectiveness of BH crisis services.

c. The bidder's plan for evaluating and meeting network adequacy with Behavioral Health crisis services, like mobile crisis services and crisis stabilization services.

Evaluating and Meeting Network Adequacy for Crisis Services

UnitedHealthcare's approach to evaluating and meeting network adequacy is focused on:

- Continuously monitoring access and availability to identify and address potential gaps
- Building capacity of the crisis network through workforce development investments and introducing initiatives to reduce the burden on the crisis system
- Enabling and partnering with local Providers to make it simpler for them to provide care

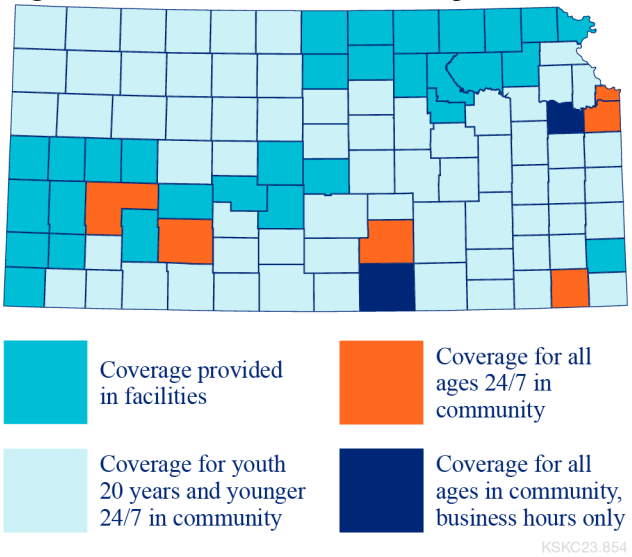
Continuously Monitoring Access and Availability

In compliance with the requirements in **Scope of Services 7.5.8.E.4.a.** Crisis Responsiveness, we diligently monitor network adequacy for BH crisis services to enable Member access to 24 hours a day, seven days a week. To enable accessible, high-quality care, we do the following:

- Review monthly network reports, such as Geographic Mapping Reports (Geo-Access) and capacity reports, to validate network adequacy for all Provider types, including those specializing in BH crisis services such as peer support, mobile crisis and crisis stabilization services.
- We overlay our network adequacy and capacity reports with areas of high utilization, incidence of type of crisis and average crisis response time.
- We routinely monitor for credentialing and recredentialing, Member and Provider satisfaction surveys, grievances and appeals and utilization reports.
- To confirm the accuracy and consistency of data, we align our systems and processes to verify the data received from all sources.

Overcoming challenges: While we are contracted with all BH crisis Providers in Kansas; crisis Providers do not adequately cover all areas of the state. The access challenges are driven by the rural and frontier nature of Kansas geography, the proximity to CMHCs/CCBHCs offering crisis services and staffing challenges for crisis Providers. As we collaborate with crisis system stakeholders to address underserved areas, we detail several initiatives we will deploy to help mitigate these challenges and provide needed BH services to Kansas Members. We are committed to supporting the satisfaction of our Members, especially in relation to timely access to crisis services and treatment.

Figure 16-4. Kansas Crisis Services Map



Building Capacity through Workforce Development and Investments

As shown in the figure, while there has been significant progress in developing a statewide crisis response system for all Kansans, coverage gaps exist statewide for adults age 21 and older. We will help build crisis network capacity by continuing to invest in Kansas initiatives that increase access to preventive care and treatment, averting Members from entering the crisis stage and freeing up capacity within the BH crisis system for Members who do enter the crisis stage, as shown in the following table.

Initiative	Description
Increase pipeline of BH Providers	Through our partnership with Motivo, master's-level BH professionals will be able to obtain the necessary clinical supervision and peer consultation to achieve full licensure and enter the workforce, increasing the delivery of person-centered crisis care to communities. Motivo has 1,200 supervisors across multiple specialties and competencies — 37% are clinicians of color and 26% have a doctorate degree. With only 59.1% of African American and 70.4% of Hispanic social workers in Kansas passing their licensure exam on the first try from 2011 to 2021, this partnership will address racial disparities within the Provider network.
Develop capacity through alternate Providers	To promote recovery, help prevent crisis and link Members to appropriate crisis supports, we will support individuals with experience in BH or SUD to become CPSS. Our in-state R&R State lead is a CPSS and provides community-based free Level II training to qualified Kansans. In addition, we will allocate $5,000 annually to help these individuals cover expenses incurred by attending any required in-person trainings, such as travel, meals and lodging.
Develop school-based system capacity	UnitedHealthcare awarded the University of Kansas Project ECHO a $350,000 grant to identify BH priorities, with particular emphasis on rural and frontier counties and communities in Kansas. The Project ECHO team developed and implemented two programs in 2023, focused on promoting student wellness. In addition, in 2024, we will partner with Supportive, a peer support organization, to deploy school-based mental health programs aimed at peer support to reduce suicidal ideation among youth and provide QPR training for school professionals.

Enabling Local Providers of Crisis Services to Expand Capacity

We will enable local crisis Providers to expand capacity by engaging Providers in value-based purchasing (VBP), providing Provider enablement support and increasing use of telehealth.

Value-Based Purchasing

We use VBP contracts to incentivize Providers to focus on preventive care and early intervention, encourage integration of physical and BH services and support innovation in service delivery. Examples of our VBPs that help reduce the burden on the crisis system include:

Experience	Outcomes of our Approach	Results
CP-PCPi and BHPi	Our Community Plan Primary Care Professional Incentive (CP-PCPi) [redacted] Our BH Provider Incentive (BHPi) [redacted]	[redacted]
Outpatient Shared Savings (OPSS)	The OPSS model focuses on improving Member engagement in care, including Members recently discharged from an inpatient BH hospital. We share ADT data with outpatient Providers, who prioritize both seven- and 30-day follow-up appointments to support community tenure.	Most recent OPSS outcomes in Kansas show a 6% increase in seven-day and a 10% increase in 30-day follow-up, with medication adherence improving 2% – 6%.
Facility Shared Savings, Readmission (FRP)	The FRP model is focused on reducing readmissions for inpatient, residential and partial hospitalization, rewarding Providers who meet identified quality metrics shown to help Members avoid 30- and 90-day readmissions when compared to Members with readmissions.	Most recent FRP outcomes in Kansas show a 13% reduction in readmission rate (compared to 2% nationally among Providers in 13 states).

Certified Community Behavioral Health Clinic Provider Enablement Program

UnitedHealthcare's provider services team was deeply involved in the Kansas CCBHC conversion, and they continue to be heavily involved as the remaining five CMHCs become CCBHCs. These collaborative relationships will be key in evolving the BH crisis delivery system. We have participated in weekly meetings with the State, CCBHCs and other MCOs since early 2022, and in countless other meetings and trainings to make sure Providers were prepared for the conversion, and to work to resolve issues both ahead of time and after the fact. Due to feedback our BH executive director received in our 2023 CMHC/CCBHC Listening Tour, we are working to share data on high-needs Members across all CCBHCs. By sharing data with Providers they otherwise may not have (ADT information and pharmacy data), we are giving Providers tools to better manage the Members they are treating.

In alignment with KDADS' goal to increase access to community-based services, advance physical and BH integration and improve the use of evidence-based practices, we are deploying our CCBHC Provider enablement program in Kansas. This program supports CCBHC and certifying CCBHC Providers with licensed clinical partners, PECs, who provide consultation and data-sharing support to enable better outcomes, processes and analytics. We commit to having three dedicated PECs in Kansas. Complementing the expertise and engagement of the Providers,

PECs bring with them additional clinical decision support data that helps Providers to better understand the holistic, integrated care needs for their patients (e.g., inpatient readmission, medication adherence, population health and risk stratification data). As the CCBHC model continues to evolve in Kansas, our Provider enablement program and VBPs will support Providers to improve quality performance while promoting progress along the Health Care Payment Learning and Action Network (HCP-LAN) continuum (i.e., from metrics-specific incentives to population-based risk-based arrangements).

Promoting Greater Use of Telehealth

Aligned to our efforts to meet Members where they are and provide consistent, high-quality care at the right time and in the right place, we promote greater use of telehealth to expand BH and crisis Provider reach, especially in areas with limited access to care. We have 740 unique BH Kansas Providers who offer telehealth services — **a 52% growth from October 2022 to October 2023.** In addition, in 2022, 79% of all Member telehealth visits were BH related and, from 2021 to 2023, 11% of crisis services were provided via telehealth. To supplement local network capacity and help fill access gaps for Members in rural and frontier counties, we are bringing additional telehealth care options to Kansas in 2024. The following solutions help Members achieve greater stability, work through difficult or challenging issues, develop coping mechanisms and provide support to help Members avoid crisis situations, thereby increasing capacity of crisis Providers.

Tool	Description
AbleTo	Provides virtual therapy programs with Kansas-licensed therapists, leveraging the principles of cognitive behavioral therapy for people with mental health needs. AbleTo is committed to timely access, with an average of six days to initial appointment. Further, 48% of high-risk patients who engage in the program have experienced a reduction in hospital admissions.
Affect Therapeutics	Provides evidence-based digital treatment program for alcohol and stimulant use disorders for people with limited access to care or those who prefer not to go to inpatient or outpatient clinics. It breaks down barriers to effective treatment and offers incentives to improve engagement. Members have access to counselors, coaches and Providers for medication-assisted treatment.
Backpack Healthcare	Provides personalized, accessible and inclusive pediatric mental health care (e.g., pediatric and family therapy and family training) through a self-care app. Users report less than a five-day turnaround from referral to first appointment, and greater than 60% of patients complete more than 10 sessions. Sixty-five percent of Backpack staff are BIPOC.

d. The bidder's plan for promoting awareness of 988 and how to access local crisis services to Members.

UnitedHealthcare's Plan for Promoting Awareness of 988 and Crisis Services

We use a comprehensive approach to promoting awareness of 988 and access to crisis services that includes direct Member education and education through community-based organization (CBO) and Provider partnerships.

Direct Member Education

We promote 988 in our *Member Handbook* and use a combination of digital and human pathways to educate Members about its availability and use, including digital education on our

myuhc.com Member portal, and through Member-directed emails and newsletters. We have created 988 educational flyers that we use at in-person health education events, to send directly to Members via email and make available to Providers. We are creating printable 988 wallet cards and crisis decision tools that are available to all Members as part of their digital Member welcome packets. We also promote 988 at community events and on social media. **Since 2019, we have attended 1,184 events and provided in-person health and wellness information to 130,369 individuals in Kansas.**

Care coordinators and other staff provide education to Members about accessing crisis services, including calling 988, calling their local BH Provider, accessing peer support, contacting their care coordinator or the UnitedHealthcare BH Crisis Support line. We help Members and their families understand the warning signs of crisis so they can either work to de-escalate the crisis or seek out appropriate help. Members at risk for crisis have a crisis plan as part of their person-centered service plan, which their care coordinator helps develop and encourages Members to keep in an accessible area in their home.

Education Through Community-Based Organizations and Provider Partnerships

We offer crisis education to interested CBOs, including how to recognize the warning signs of someone approaching or in crisis and connect them to 988 resources. We partner with CBOs to support free crisis and 988 education through such trainings as MHFA, Seeking Safety, and QPR creating a larger pool of individuals in the community capable of assisting someone in crisis:

- **A $75,000 donation to Horizons Mental Health Center** to provide MHFA.
- **A $100,000 donation to Community Behavioral Health, Inc**. to expand MHFA training for youth, teens, adults and older adults and train educators in Spanish version of programs across the state's CMHCs.
- Our R&R State lead engages in numerous committees, subcommittees and advisory boards throughout Kansas that promote awareness of 988 (e.g., Governor's BH Planning Council Peer Subcommittee, National Board for Federation of Families).

Utilization Management and Services

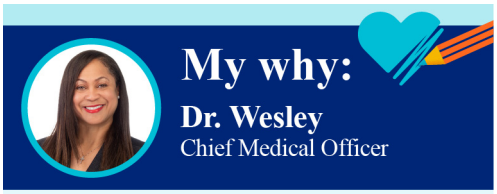
17. Describe the bidder's approach to increasing the provision of screening and tobacco cessation services to KanCare Members disproportionately affected by smoking and tobacco use. Include an example of a similar approach the bidder has taken with similar populations that was successful, the measurable impact achieved, and why the bidder anticipates the approach will result in improvements in KanCare.

Screening and Services for Members Disproportionately Affected by Tobacco

From the Healthy Kansans 2030 State Health Assessment Report, our partnership with KDHE's Community Health Promotion program and our involvement in the State Health Assessment and Improvement Plan priority workgroups, we know tobacco cessation is priority for the State and its KanCare population. We use a three-pronged approach to increase the provision of screening and tobacco cessation services for Members disproportionately affected by smoking and tobacco:

- **Identify** Members who are disproportionately affected by smoking and tobacco use at both a population health and individual level
- **Engage** identified Members in the provision of tobacco cessation services
- **Collaborate** with Providers and local stakeholders to educate Members and promote cessation

Following descriptions of these processes, we include an example of a similar approach with a pregnant population that we anticipate will result in improvements in KanCare.



"A primary reason I chose a career in medicine was the premature death of my maternal grandparents from lung cancer. As a teenager, my grandmother came to live with us and was placed on hospice where she succumbed to the disease. As the chief medical officer, my grandparents' struggles with nicotine motivates me to make sure our approach to tobacco cessation is not only Member focused, but respectful of the Member's journey and its impact on their loved ones. By meeting the Member where they are on their journey, our KanCare Members receive the best care, respect and support possible."

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Identifying Members Disproportionately Affected by Smoking and Tobacco Use

We acknowledge that the authors of the Healthy Kansans 2030 State Health Assessment Report identified the populations in Kansas disproportionately affected by smoking and tobacco use (as of 2019) as teens who smoke or use electronic vapor products; Kansans who have low household income, did not graduate from high school, are uninsured, unemployed, or report poor mental health; and Kansans living in rural counties in the southeast corner of the state who also have the lowest median household income. Additionally, the Kansas Tobacco Control Strategic Plan identifies the following populations as priority: American Indian, Black Americans, people with lower income, disabilities or behavioral health conditions, people who identify as LGBTQ+, pregnant and postpartum women, youth and young adults. Recognizing that our Members are a subset of the total population, we harness these insights in addition to those in our own data. We have several tools and teams to help us identify our disproportionately affected populations and deploy strategies at both the population level and Member level.

Identifying Disparate Populations that Use Tobacco

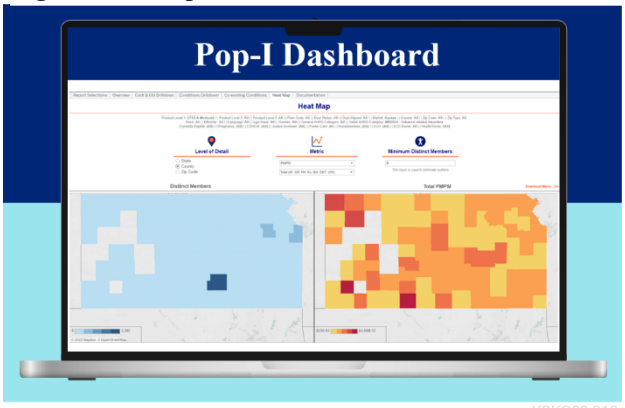
Data is instrumental to our process of identifying Members disproportionately affected by smoking and tobacco use. Our data analytics tools enable stratification according to demographic data such as race, ethnicity, language, location and sexual orientation and gender identity. This health equity approach allows us to gather quantitative and qualitative data to unearth emerging

trends, identify disparate populations and track progress of targeted initiatives, including tobacco use.

Our population health management and data analytics teams support the local team by analyzing tobacco user data to identify disparities and trends by age, race, culture, gender or geographic location. Through this population lens we can track trends and pinpoint disparities at a macro-level to inform targeted interventions that address population specific needs and barriers to quitting. Following are examples of disparate populations we have identified in Kansas:

- Black and African American Members account for 16.0% of our tobacco users but only 13.3% of our membership.
- Female Members aged 22 – 44, common childbearing years, account for 32.5% of our tobacco users but only 24.8% of our membership.
- Individuals with anxiety and depressive disorders have tobacco use rates that are 9.3% higher than the overall population.

Figure 17-1. Pop-I Dashboard



Our Population Insight dashboard (Pop-I), which we recently launched in Kansas, is another powerful self-service tool our clinical teams use to identify Members who smoke or have certain health conditions indicating a person uses tobacco or is using cessation medications. This tool helps our care coordination team identify disparate populations for intervention and outreach. As shown in the figure, one view of data in the Pop-I dashboard shows diversity by Kansas county. With Pop-I, data can be filtered and sorted by population and outcomes across diverse groups. It fuses clinical and Member-specific data according to various factors — including clinical diagnosis, race, ethnicity, language, gender, age and geographical location — to further identify disparities within the broader population. With Pop-I, we analyze Kansas comorbidities tied tobacco use disorders with other prevalent conditions. For example, through evaluation of the data 48% of Kansas tobacco users also have a co-existing condition of anxiety. These insights allow us to hone approaches to engagement and collaboration. We have currently implemented several programs to support disparate populations and describe additional programs that will be implemented in the future.

Identifying Individual Members that Use Tobacco

We use every Member touchpoint, including new Member welcome calls, as an opportunity to identify Members and help them address their tobacco use.

The State's Health Screen Tool (HST) for pediatric and adult populations is an important step to identifying individuals who may benefit from a person-centered approach to help them quit smoking. A Member can complete the HST as early as their new Member welcome call. If that Member self identifies as a smoker during the call, they are immediately referred to the KDHE KanQuit program and resources. Because the HST is the main way we learn about Members who use tobacco, we pay close attention to HST completion rates. Over the past three years, the

number of Members completing an HST has steadily increased. Over 90% of Members reached have completed their HST, exceeding the 80% HST completion requirement. While the number of Members indicating tobacco use in their HST has increased, the overall percentage of Members reporting tobacco use has decreased to below 20%. This percentage is higher than the national average of 15.5% reported in the Healthy Kansans 2030 report. Following the HST, we use risk stratification techniques and HRAs to identify and prioritize individual needs and target populations for care coordination, education and outreach. Along with services identified in their person-centered care plan, we collect data from behavioral health screenings that their PCPs, Community Mental Health Centers (CMHCs) and other behavioral health Providers complete.

Engaging Identified Members in Tobacco Cessation Services

We use a combination of digital and human pathways to engage Members and support them in accessing tobacco cessation services. Care coordination is one of the human pathways. Digital pathways include our Member portal, e-newsletters and online educational information specific to smoking cessation services and resources. Additional touchpoints from our care coordination programs provide us the opportunity to identify Members disproportionately impacted by tobacco use. Upon identification of a disparate population or an individual Member with cessation needs we implement engagement strategies to connect them to programs and resources available to help them quit through direct Member engagement and population level communications.

If Members identify as a tobacco user, we share information, such as KanQuit (*KSquit.org*) and the quit line 1-800-QUIT-NOW, and offer referrals to tobacco cessation resources. In some instances, this engagement is directly with our member services team, or they may refer the Member to a Community Health Worker (CHW). In other cases, our care coordinators maintain at least monthly contact with Members embarking on their cessation journey to provide support and encouragement. We also refer Members to their PCP, who may provide cessation counseling or prescribe medication to aid in tobacco cessation, in accordance with evidence-based guidelines. As we proceed into the new KanCare Contract, we are committed to continued support of Project ECHO and its future initiatives regarding tobacco cessation. Shown in the figure is an article about the dangers of vaping we posted in our Member newsletter, *HealthTalk*, in Summer 2023.

Figure 17-2. Article in Member Newsletter

Quit vaping

Put down that vape

E-cigarettes are as unhealthy as regular cigarettes

A 2022 study[1] found that more than 2.5 million teenagers use e-cigarettes, or vapes. This is about 14% of high schoolers and 3% of middle schoolers. Of those, 1 in 4 vape every day, and 85% use flavored products.

People often think e-cigarettes are safer than regular cigarettes. This is not true. Both contain nicotine, which is addictive. One Juul pod has as much nicotine as a whole pack of cigarettes.

E-cigarettes also have toxic chemicals that can damage your child's lungs and brain. Some vaping devices look like USB drives or pens, making it easier for your child to hide them.

Vaping is dangerous for adults, too. While it has some of the same long-term risks as cigarettes, it can also cause sudden lung damage in people of any age. This can be permanent or deadly.

[1] Centers for Disease Control and Prevention (CDC), 2022.

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We understand each person's journey to tobacco cessation is unique. Therefore, our approach to engaging Members who want to quit uses motivational interviewing that encompasses the foundational stages of change. Our care staff are trained in techniques such as motivational interviewing and have strategies in place to engage with a Member wherever they are in the process.

The following table outlines the engagement strategies for each foundational stage of change.

Stage of Change	Engagement Strategy
Pre-Contemplation Tobacco user is unaware a problem exists or consequences it has on their health.	▪ Educate ▪ Provide facts ▪ Explore pros and cons
Contemplation Aware of the problem; interested in change but uncertain about taking the necessary steps to quit tobacco.	▪ Openly discuss challenges ▪ Affirm strengths and prior accomplishments ▪ Deeper exploration of pros and cons
Preparation Problem awareness and engagement in planning activities that will support future change; readying self to act.	▪ Help identify time-specific goals and strategies ▪ Help identify social supports ▪ Explore tactical options to achieve goal
Action Engaged in steps that are specific to achieving their goal. Day 3 of quitting is often the hardest for tobacco users.	▪ Identify and plan for high risk or relapse situations ▪ Reinforce milestone accomplishments ▪ Identify other actions that support goal achievement
Maintenance Generally, change behaviors that have been engaged for greater than six months; a state of accomplishment that still has risk of relapse.	▪ Explore relapse risk ▪ Establish new goals to support long-term maintenance ▪ Explore new pleasures
Relapse A return to use of tobacco, which can be short- or long-term.	▪ Provide unconditional positive support ▪ Explain relapse is part of the change and recovery process ▪ Explore the antecedents to the relapse

Our care coordinators and CHWs are trained on how to assist Members to quit smoking or end their tobacco dependence. At least annually, our care coordinators and CHWs attend multiple training courses that increase their cultural competency and cultural humility. These courses include but are not limited to Cultural Competency, Trauma Informed Care, Motivational Interviewing, and Health equity. We make certain engagement is culturally competent since disparities can be found based on cultural attitudes about tobacco use, age, gender and other social or demographic factors.

Often, individuals disproportionately affected by tobacco use are those who have diagnoses usually brought on by smoking, such as emphysema or COPD. These Members often have comorbid conditions and are receiving care management services, which is the avenue for our care managers and care coordinators to work with them one on one as part of their person-centered service plan where we can set tobacco cessation goals, if that is the Member's choice. As Members set their health improvement goals in their plan of care, our care coordination staff support them and provide the tools necessary to help them quit. For example, our care coordination staff refer Members to tools available through KanQuit, and they assist with getting cessation medications, connecting with local support groups (e.g., through support groups run by CMHCs, National Alliance on Mental Illness [NAMI] and other organizations) and working one on one with Members to listen and offer help aligned to their plan of care.

Figure 17-3. KanQuit Resources

Member communications and digital engagement strategies allow us to reach a large audience to curb trends at a population level. Our *Member Handbook* includes details on tools and resources available and information on how to contact member services, with phone numbers and websites to support those who want to quit. We include the KanQuit hotline information within every issue of our Member newsletter, *HealthTalk,* and at least annually, we post articles about tobacco cessation in this newsletter. The figure depicts the KanQuit resources we include in every issue of *HealthTalk*, in multiple languages. With the alarming trend of vaping and e-cigarette use, especially among teens, we also use the *HealthTalk* newsletter to explain the dangers of vaping for our young Members and parents. To educate Members about the health risks of tobacco use, we include KanQuit brochures and materials in information sent to Members and hand out KanQuit materials at local events.

Collaborating with Providers and Local Stakeholders to Educate and Promote Cessation

Recognizing that tobacco use is a community wide problem requiring a community wide solution we engage with a variety of partners across the state to promote tools and resources encouraging tobacco cessation. Through regularly scheduled provider training, we remind PCPs that they can be reimbursed for providing cessation counseling, which helps increase support for Members with motivation to quit. From 2021 to 2022, we saw an increase of 22.7% of these billable codes with an additional slight increase over the first half of 2023. We also remind Providers of the resources available to Members through their prescription benefits, VABs and the KanQuit program.

To make sure training is made available to Providers who interact with our Members, we will sponsor scholarships to attend the Tobacco Treatment Specialist Training that the Kansas School of Medicine offers. This training is designed for CHWs, health educators, respiratory therapists, dental hygienists, substance use disorder counselors, RNs, LPNs, physicians and other social service professionals. We will use our data and the expertise of our partners to identify the most impactful way to fund the scholarships. For example, our data indicates Members in rural communities are more likely to report tobacco use on the HST, than Members in urban communities. This data might suggest a shortage of Providers with the necessary training, and scholarships should be awarded by geography.

Also, we will continue to actively participate in the Behavioral Health Tobacco Workgroup. We are aware that this workgroup took a hiatus during 2023 and is resuming meeting cadence in 2024. Members of our staff who participate in this workgroup have been invited to workgroup meetings and look forward to being a part of the solution to Kansas' tobacco cessation initiatives.

The statewide Behavioral Health Tobacco Workgroup was initially formed as a class project at the Kansas Leadership Institute. The workgroup includes representatives from local health departments, incumbent KanCare managed care organizations (MCOs), the American Cancer

Society, local CMHCs and the NAMI. This workgroup focuses on reducing tobacco use among Kansans with behavioral health conditions by promoting adoption and showing local businesses and employers how to implement tobacco-free practices for visitors to their property and employees. Over 50 Kansas organizations have endorsed the Kansas Tobacco Guideline for Behavioral Health Care. The Guideline contains helpful information about how to enact a comprehensive tobacco-free policy in buildings, vehicles, areas with common grounds and expectations for employees and visitors within the building or property.

To better support our Members in quitting and encourage them to take advantage of tobacco cessation services, we invited KDHE's Office of Community Health Promotion to speak at our Grand Rounds. These are quarterly meetings our clinical teams attend to learn about new or changing dynamics in Kansas that help them to better serve Members. Employees who attend Ground Rounds include care coordinators, CHWs and clinicians. At our March Grand Rounds, KDHE presented information on KanQuit program services, including incentives and covered medications, and provided education on how to better support people trying to quit.

Tobacco Cessation Value-Added Benefit

Beyond education, we will offer rewards when Members quit using tobacco. Effective in 2025, we will offer a value-added benefit to reward Members who successfully quit using tobacco. Members will receive a $25 gift card for use at a retailer for CMS-approved health items.

We have also committed to adding a value-added benefit in 2025 to reward our Members who quit using tobacco. In addition, we offer a multitude of VABs promoting healthy lifestyles and rewarding Members for making their physical health, mental health and wellness a priority, such as Healthy Rewards, Wellness for All, Wellness for Kids and Self Care by AbleTo. The Supportiv value-added benefit will be introduced in five Kansas counties. Supportiv is a school-based mental health program providing online, on-demand peer-to-peer mental, emotional and social support in small group chats available to teens. Supportiv can work across multiple topics mattering to teens, including tobacco cessation.

Along with these collaborative partnerships, we will work in closer collaboration with other MCOs to strengthen the unified approach to public messaging and education. For example, a broader educational campaign geared toward specific populations — such as teens, parents, educators and adults with at-risk indicators — can help to improve outcomes.

A Successful Approach to Cessation Used with Pregnant Membership

In Virginia, we introduced a successful tobacco cessation initiative with pregnant Members that we will expand in Kansas. We anticipate elements of these initiatives can lead to successful outcomes in Kansas.

Virginia: Tobacco Cessation in Pregnant Members

In alignment with the Commonwealth of Virginia's 2020 – 2022 goal to prevent nicotine dependency, we use two methods to identify women who are pregnant and smoke:

- Using an obstetrical risk assessment tool (OBRAF) that identifies the Member's tobacco use
- Isolating pharmacy claims using an algorithm to identify pregnant Members who use tobacco or tobacco cessation medications

Upon identifying those who are pregnant and use tobacco, our member services outreach team contacts the identified Member to offer counseling and cessation support.

Measurable Impact this Approach Achieved

Of the Virginia Members who were identified via a maternity risk assessment tool, 87% said yes to our offer of counseling and smoking cessation support. Of the Members identified through pharmacy claims, 53% engaged with their care coordinator to stop smoking. Overall, there was a 33.4% increase of tobacco cessation in pregnant Members from 2021 to 2022. Given their effectiveness, our colleagues in Virginia continue this level of intervention and continue to analyze effectiveness of intervention methods.

How Our Approach in Virginia Can Result in Improvements in Kansas

Given the effectiveness of this approach and similarities in membership demographics, we can apply the same methods to identify Members and conduct outreach. In addition, we can use HST and HRA results to capture a larger number of Members who are pregnant and smoke. We have an OBRAF in Kansas along with an incentive program for both Providers and Members. Providers receive an incentive for digital submission of the form and members receive an incentive for a timely prenatal visit. Pharmacy claims are a rich resource for identifying pregnant Members receiving nicotine replacement, tobacco or tobacco cessation products in Kansas.

As in Virginia, in Kansas, our pregnant KanCare Members undergo risk stratification to determine if their pregnancy is low, rising or high risk. High-risk stratification triggers an alert in the Member's care coordination record whereupon a maternal CHW or care coordinator immediately engages the Member in accessing prenatal care and services. Identification as a pregnant mom who uses tobacco places her as rising risk. Currently, only a subset of Members identified as rising risk receive prenatal and postpartum case management. This subset of Members are pregnant, Black, Indigenous, People of Color (BIPOC) and live in a county with an identified disparity in birth outcomes. This change in risk enables this disproportionately affected population to receive the same care coordination services as high-risk Members.

We have the screening and stratification infrastructure in place to identify pregnant moms who are also tobacco users. With the additional care coordination populations identified in this contract we will also have the resources in place to offer case management services to all pregnant moms and postpartum moms, including those stratified as rising risk.

Utilization Management and Services

18. Describe in detail the proposed value-added benefits the bidder intends to offer KanCare Members, including the scope of each benefit (including any limitations), the target population, and the anticipated benefit to KanCare Members. Include the bidder's approach to assessing the impact and value of the value-added benefits to Members.

Offering value-added benefits (VABs) has always been part of our service delivery for our KanCare Members. With each VAB, we carefully consider membership interest, need, motivational factors and ease of use. After implementing a VAB, we monitor Member use of the VAB and use Member feedback and satisfaction surveys to determine its effectiveness in achieving the desired outcome. As part of our continuous quality improvement activities, we use data and Member feedback to create new VABs or to augment our existing VAB offerings. We attribute the appeal of our VABs to be a significant factor in KanCare Members choosing UnitedHealthcare for their health plan.

In the response that follows, we describe the VABs we offer to our KanCare Members and our VAB product development lifecycle. With over 20 pages of detail about each VAB, we organized our response using a VAB summary table on the second page herein and provided detailed VAB tables on the last pages, after describing our approach to assessing the impact and value of the VABs we offer.

The Value-Added Benefits We Offer KanCare Members and Our Approach

With any decision to offer a VAB, we first consider how it fits into Kansas' integrated service delivery system, its meaningfulness for Members and how we can make it available statewide or for Members within a specified cohort or targeted population. To align our VAB offerings to State priorities and appeal to Members, we employ a VAB product development lifecycle. As shown in the figure, the cycle entails listening, acting, evaluating and improving. Our VAB committee and teams interact with Members and the Provider community to:

Figure 18-1. Voice of the Member Loop

- **Listen** – At community events and via surveys, we listen to Members to gain understanding of what they want and need. We gather input from our Member Advisory Committee (MAC), Providers and stakeholders through direct interactions, listening sessions and surveys.
- **Act** – Based on feedback, we develop and augment VABs. We conduct awareness campaigns tailored to the VAB audience. Awareness campaigns include activities such as promoting the VAB at local events, training staff and Providers, working with community partners to spread awareness and updating newsletters, the *Member Handbook*, Provider manual and websites.
- **Evaluate** – At regular intervals throughout the year, the VAB committee collects information and analyzes data about each VAB to determine its effectiveness and assess the impact, value and satisfaction to our Members.
- **Improve** – The VAB committee uses evaluation results for each VAB to decide whether to continue offering it to enhance it or discontinue it in favor of a new VAB.

We design each VAB to support a defined population with diverse needs and challenges, tailored to Kansas and the KanCare program. Using feedback and ideas we receive from the State, surveys, MAC and our care coordination staff, we identify opportunities to introduce new programs or enhance existing offerings. We consider how the VAB enhances Providers' ability to expand access to clinical, telehealth and behavioral health services and resources promoting health and wellness.

Member Compliments Healthy Rewards

"The extra benefit from UnitedHealthcare helps me keep my kids active and healthy. They offered us options and helped us enroll. Now my friends want to change to UnitedHealthcare."

– A KanCare UnitedHealthcare Member

The evolution of our Educational Advancement VAB is an example of this loop in action. Initially, this VAB was designed to help Members obtain their General Educational Development (GED) or take coding classes. After listening to Members and obtaining feedback about other types of courses they have interest in taking, we added more covered educational options. Over the years, this VAB evolved into a comprehensive educational advancement support covering resumé writing, English as a second language and more. **From 2022 through the third quarter of 2023, KanCare Member use of this VAB increased 246%.**

In the following table, we provide a summary of the VABs we offer in 2023 and 2024 and plan to offer in 2025. We describe all VABs in detail — including the scope of the benefit, limitations, target population and anticipated benefit — later in this response.

To Improve Health Outcomes, Reduce Disparities and Improve Member Experience	
These VABs that promote behavioral health wellness for Members with specific needs:	
▪ ATTACh** (Caregiver Peer Support)	▪ Seeking Safety Training
▪ Mental Health First Aid Training	▪ Self Care by AbleTo* (Life Coaching)
▪ On My Way (Foster Care Youth Life Skills)	▪ Supportiv** (School-Based Support)
▪ Pyx Health (Social Isolation Support)	▪ Weighted Blankets
These VABs support healthy pregnancy and maternal care:	
▪ Babyscripts (Maternal Health Incentives)	▪ Lactation Consultation
▪ Care Angel (Virtual Nurse Assistant)	▪ Nutrition: High-Risk Pregnancy*
▪ First Trimester Prenatal Exam Reward	▪ Nutrition: SNAP Cooking Classes
▪ Healthy First Steps	▪ Pack 'n Play*
▪ Home Visits (Maternal Health Incentive)**	▪ Wellhop (Support Group)
These VABs support specific KanCare Member populations with specific needs:	
▪ Adult Dental Care	▪ Post-Discharge Meals
▪ Air Purifier*	▪ School Supplies for Foster Kids
▪ Dining with Diabetes	▪ Tobacco Cessation Incentive**
▪ Medication Lockbox**	▪ Vision: Eyeglass Frames Upgrade
▪ Pest Control	
These VABs promote healthy lifestyles and wellness:	
▪ Bike Helmets*	▪ Reward for Health Screening Tool

▪ Healthy Rewards Incentive	▪ Wellness for All (Fitness Bundle)
▪ Personal Care Gift Card* for LTSS	▪ Wellness for Kids (Fitness Bundle)
▪ Personal Care Gift Card Frontier and Rural*	
These VABs promote independence for our KanCare Members:	
▪ Bus Passes	▪ Internet Access
▪ Educational Advancement	▪ Walmart+ ** (Home Delivery)
▪ Enhanced Transportation Support	▪ Wellness Calendar
▪ Free Mobile Phone	

*Indicates new VAB added for 2024. **Indicates VAB for 2025 pending state approval.

UnitedHealthcare will comply with the requirements described in the **Scope of Services 7.3.4** Value-Added Benefits. We will submit a value-added benefit report to the State in accordance with the State's format and frequency, and we confirm we do not use community reinvestment funding to pay for VABs. Annually, we submit the VABs to KDHE for the upcoming calendar year. Although VABs are not part of the State's formal grievance and appeals process, we monitor Member concerns or complaints regarding VABs and address each concern. We do not pass the cost of VABs to Providers or Members, nor do we report them in our Medical Loss Ratio reporting. Our VAB costs are noted in the managed care organization (MCO) Reporting Template (MRT) information we submit for ratings, which shows the specific VAB identified through encounter data, when applicable. We confirm that we comply with marketing activity prohibitions specific to Medicaid programs and per 42 CFR § 438.104. Also, we notify Members and Providers about the availability of our VABs through ongoing awareness campaigns and materials distributed at community events and as part of our ongoing onboarding, educational and outreach activities. **From 2021 to 2023, our awareness campaign resulted in a 170% increase in KanCare Member use of VABs.**

Increased Member Use of VABs

From 2022 through the third quarter of 2023, KanCare Member use of our VABs increased from 16% to 25%. Notable increases by VAB are:

- Educational Advancement increased 246%
- Healthy Rewards Incentive increased 388%
- Reward for Health Screening Tool increased 22%
- Dental Care increased 74%

Assessing Impact and Value of VABs to KanCare Members

Before implementing a VAB, we follow our Quality Assessment and Performance Improvement (QAPI) approach to confirm the proposed VAB supports our mission of improving the health of the Members we serve and aligns with the State's goals and priorities for the KanCare program. Applying our QAPI methods supports a thoughtful, organized approach to implementing, managing and evaluating the effectiveness of our VABs.

At the tactical level, we established a VAB committee to apply a consistent process for evaluating the effectiveness of our VAB offerings. Our VAB committee consists of subject matter experts from our teams interacting with Members, such as call center staff and care coordinators, as well as operational team leads who participate in implementing and administering VABs. The committee meets quarterly to discuss VABs from the former year to adjust and improve, if needed, for the upcoming year. The VAB committee evaluates a VAB's efficacy by modeling expected engagement and value to Members by researching engagement and outcome metrics across

available racial, ethnic and geographic information. They consult our legal and regulatory compliance leads, who review the proposed benefit to verify it aligns with federal and state laws and rules as well as relevant Office of Inspector General (OIG) opinions. Then, the VAB committee brings the VAB concept, design and materials to the leadership team for review and approval.

After we implement a VAB, we evaluate use, assess costs and look for ways to improve it annually, using the data we collect. To verify their relevance and effectiveness, we review utilization data routinely as a key measure of Member interest in a VAB, as well as Member surveys and feedback from our MAC. We monitor the service offering's efficacy in consideration of geographic and demographic utilization patterns (i.e., variances by urban versus rural and frontier locations and by population type) and adjust outreach, messaging and communication based on the information we collect and evaluate.

In addition to MAC feedback, our VAB committee participates in Member listening tours to hear directly from KanCare Members across Kansas about their interests and experiences regarding access to services. We augment and enhance VABs based on direct feedback from individuals at public forums, including health fairs, baby showers, back-to-school fairs and other community events. With what we learn from feedback sources, we develop VABs to fill gaps. For example, our adult Members were vocal about dental services, prompting us to increase the dental benefit to $500 so Members can get restorative dental services.

Informing Members of Our Value-Added Benefit Offerings

Typically, Members first learn about our VABs during the KanCare enrollment process and KanCare VAB side-by-side document. To complement the State's approach to raise KanCare Members' awareness of VABs, we send our new Members materials about our VABs, such as welcome packets, calls and emails. As shown in the figure, we give display materials, such as window clings and handouts, to partners, like the YMCA, where Members access the VAB. Each VAB is included on our public website. Additional Member materials containing details about VABs and how to access a VAB include the *Member Handbook*, Healthy First Steps maternity materials and flyers on VABs such as Healthy Activity and Mental Health First Aid training.

Figure 18-2. Window Cling

We promote our VABs through our community partners that deliver the VAB. For example, YMCAs, Boy Scouts, Parks and Recreation and Boys & Girls Clubs promote the VABs we offer by putting the window clings, flyers and brochures we supply to them on display at their sites. For OneCare Kansas Members,

we partnered with dedicated OneCare program staff at participating Provider sites to directly deliver relevant VABs to the Member along with information about other VABs.

During regular community events, including presentations to our MAC, we provide information about our VABs to Members. Our care coordinators inform Members of our VABs and encourage Members to leverage VABs for their needs. Members can call member services to get more information about VABs and to get the VAB that interests them. We conduct extensive educational efforts, such as lunch and learn meetings, to inform Providers, community organizations and Members about the benefits and how to obtain them.

Making Providers Aware of Our VAB Offerings and How to Assist Members with VABs

Our provider services team educates Providers about our VABs through initial and ongoing Provider training, bulletins, the Provider Administrative Guide and Provider portal. Depending on the VAB and Provider audience, our clinical practice consultants (CPCs) or Community Health Workers (CHWs) conduct targeted training for certain Provider types. For example, obstetricians, PCPs and pediatricians receive training regarding our VABs tied to maternal care, pregnancy and postpartum care that includes showing Providers how to encourage the Member to obtain the VAB and how to make referrals. For VABs geared toward a unique service or population — such as the dental VAB — dental care and HCBS Providers receive targeted training regarding the VABs we offer exclusively for those populations.

To share updates and information about our VABs, we meet frequently with CBOs, such as El Centro, Catholic Charities and Headstart, and Providers, such as GraceMed, Community Center of Southeast Kansas and Vibrant. In turn, they share this information with Members. By promoting our VABs through CBOs, KanCare Members gain awareness and receive information about how to access our VABs in a culturally appropriate manner from a source they trust. We conduct staff training virtually, in person and in collaboration with local associations, Provider groups, CHW coalitions and local health departments. We provide a photo of recent Kansas graduates of our Mental Health First Aid training. This popular course, which is open to Members, Providers, people in the community and employees is offered in English and Spanish. This particular class, shown in the photo, was entirely Spanish-speaking.

Figure 18-3. Mental Health First Aid Training

Employee Training Regarding Value-Added Benefits

To promote VABs and assist Members in getting VABs, we provide updates and ongoing training for employees interacting directly with Members and Providers. Employees undergo training about VABs as part of new employee training and at least annually thereafter. If an administrative change occurs with a particular VAB that would affect how Providers refer

Members to the VAB, we notify Providers before the change and provide them with the new details.

For Consideration:

The remainder of this response describes in detail the VABs we offer to KanCare Members and those we plan to offer in 2025, including the scope of each benefit (including any limitations), the target population and the anticipated benefit to KanCare Members.

Value-Added Benefits Promoting Mental Health and Wellness

In the tables that follow, we describe our VABs that promote mental health and social wellness for Members with specific behavioral health needs. Each VAB supports a targeted population and serves as a bridge to help Members by providing preventive behavioral health services for families.

ATTACh – planned for 2025

Value-added benefit to provide preventive behavioral services for children and families	
Scope and Description	Association for Training on Trauma and attachment in Children (ATTACh) is an international coalition dedicated to promoting awareness of trauma and attachment disorders in children. ATTACh is a preventive behavioral health program created to bring hope and resources to parents, caregivers and professionals who work with infants, toddlers and children impacted by trauma or at risk for behavioral health conditions. This VAB will provide an ATTACh parent membership, which gives them access to parent support calls, one on one support with ATTACh staff, registration to conferences, resources and community support groups.
Limits or Authorization Requirements	**Limits:** Available to all families with young children. **Authorization Requirements:** No prior authorization requirements.
Target Population	Families with young children (infant and toddlers) at risk for behavioral health conditions.
Anticipated Benefit to KanCare Member	Expanded preventive behavioral health services to families with young children at risk for behavioral health conditions by providing ATTACh membership to the parent.
How Members can access this VAB throughout the year	Members can call member services, their care coordinator or CHW to learn more about this benefit.

Mental Health First Aid Training

Value-added benefit to educate and empower Members to improve their mental health	
Scope and Description	Community partners, Providers, Members and other individuals can take an eight-hour course on how to identify, understand and respond to signs of mental illnesses and substance use. Participants learn a five-step action plan to help an individual connect with professional, peer, social and self-help care. Training curriculum is

Value-added benefit to educate and empower Members to improve their mental health	
	geared toward specific audiences, including adults, youth, individuals living in rural and frontier counties, older adults and first responders.
Limits or Authorization Requirements	**Limits:** Events may not be held in all areas. **Authorization Requirements:** No prior authorization requirements.
Target Population	All Members
Anticipated Benefit to KanCare Member	Increased education around mental health and substance use support and to support Members in crisis. This program is offered in both English and Spanish to youth and adults.
How Members can access this VAB throughout the year	Members can register to attend training on our website. We promote this benefit through flyers, posters, email invitations, videos, community partners, hosting organizations, radio interviews and social media.

On My Way

Value-added benefit to address health equity and SDOH for youth transitioning to adulthood	
Scope and Description	On My Way is an online support program and teaching tool open to all youth and young adults, including young adults who are aging out of the foster care system or transitioning to independent living. This program: ▪ Targets SDOH via life tracks feature: education, transportation, finances, employment and housing ▪ Uses technology and gamification as a resource for Member engagement ▪ Encourages annual well visits and regular doctor visits ▪ Addresses behavioral health topics and resources ▪ Sets reminders for flu shots, filing taxes, re-applying for Medicaid ▪ Enables personalized resources On My Way is a teaching tool aimed at helping youth and young adults to learn life skills that lead to independence, such as money management, housing, job training and preparing for college.
Limits or Authorization Requirements	**Limits:** Unlimited access once the youth creates their On My Way account online. **Authorization Requirements:** No prior authorization requirements.
Target Population	Open to teens and young adults, aged 14 through 26
Anticipated Benefit to KanCare Member	Education and preparation for successful transition to independent living for youth and young adults who are transitioning to adulthood.

Value-added benefit to address health equity and SDOH for youth transitioning to adulthood	
How Members can access this VAB throughout the year	Members can go to *uhcOMW.com* and complete the brief registration. This tool can also be found through our website. Members can call member services, their care coordinator or CHW to learn more about this benefit.

Pyx Health

Value-added benefit to enhance access to behavioral health resources	
Scope and Description	Pyx Health is a mobile app offering Members a way to combat social isolation and loneliness by giving them access to compassionate people who can listen and connect them to resources can access support 24 hours a day, seven days a week. This benefit promotes independence allowing Members to remain at home and learn coping skills to avoid social isolation.
Limits or Authorization Requirements	**Limits:** Members 18 years and older can access. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members 18 years and older.
Anticipated Benefit to KanCare Member	Connection to support to overcome isolation and loneliness.
How Members can access this VAB throughout the year	Members can download the free app from the Apple App Store or Google Play. Members can call member services to learn more about this benefit.

Seeking Safety Training

Value-added benefit to educate and empower Members experiencing trauma or abuse	
Scope and Description	Members, individuals, peers and Providers can participate in an eight-hour facilitator training course on 25 different evidence-based safe coping skills to help adults with trauma or substance use issues. Participants will receive a book and can lead Seeking Safety Support Groups in their communities to provide preventive behavioral health education.
Limits or Authorization Requirements	**Limits:** These are in-person events (i.e., not virtual) held in strategic areas of the state throughout the year. **Authorization Requirements:** No prior authorization requirements.
Target Population	Transition-aged youth and adults over age 18.
Anticipated Benefit to KanCare Member	This training helps adults, children and your who attend to learn coping skills to gain a sense of safety from situations of trauma and substance use.

Value-added benefit to educate and empower Members experiencing trauma or abuse	
How Members can access this VAB throughout the year	We attempt to hold in-person events in major areas of the state and multiple times over the course of the year. Members can call member services to learn more about this benefit.

Self Care by AbleTo

Value-added benefit to educate and empower Member to overcome life challenges	
Scope and Description	Self Care by AbleTo is an app that gives Members free access to life coaching, therapy and peer support for dealing with stress, anxiety and depression. This app is designed to provide Members with behavioral health services on an as needed basis.
Limits or Authorization Requirements	**Limits:** Members aged 13 and older can access. **Authorization Requirements:** No prior authorization requirements.
Target Population	Available to Members aged 13 and older.
Anticipated Benefit to KanCare Member	Emotional health and self-service tools to reduce stress, anxiety and depression. Note: Formerly known as Sanvello.
How Members can access this VAB throughout the year	Members can visit *ableto.com/begin* and sign up with their health plan ID as their access code. Members can call member services to learn more about this benefit.

Supportiv – planned for 2025

Value-added benefit to provide online, on-demand peer support mental health tool for teens	
Scope and Description	Supportiv is an online peer support tool for mental, emotional and social support with hyper-relevant resources for high school aged teens who do not typically use mental health care. Online support has live-moderated peer-to-peer small groups and chats. This is an online tool, not an app, and works on any type of technology device. Supportiv is available 24 hours a day, seven days a week, and calls are anonymous with no IDs or profiles needed. Benefit covers the cost for students to join and use real-time resources.
Limits or Authorization Requirements	**Limits:** Available to all teenage students attending high schools Supportiv serves. The geographic service area is limited to Allen, Ellis, Neosho, Saline and Wichita counties. Limiting to these rural counties and Wichita County allows us to offer this service to more students for greater impact. **Authorization Requirements:** No prior authorization requirements.
Target Population	Teenage Members, specifically targeting rural school districts, based on suicide risk.
Anticipated Benefit to KanCare Member	Supportiv helps high school students who attend the schools where Supportiv offers services to have access to mental health resources

Value-added benefit to provide online, on-demand peer support mental health tool for teens	
	through the service Supportiv provides. Data indicates that 86% of students feel better after engaging with Supportiv.
How Members can access this VAB throughout the year	Members can call member services, their care coordinator or CHW to learn more about this benefit. Supportiv will be working with the schools to make them aware of this service and we plan to promote this through local Certified Community Behavioral Health Clinics (CCBHCs).

Weighted Blankets

Value-added benefit to promote wellness for Members experiencing anxiety or stressful sleep	
Scope and Description	We give weighted blankets to Members who are in foster care or who have been diagnosed with autism or serious emotional disturbance (SED) or experiencing anxiety due to trauma or their diagnosis. Blankets have three weight options: light, medium or heavy.
Limits or Authorization Requirements	**Limits:** One blanket per Member per year. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members who are in foster care or on the autism or SED waiver.
Anticipated Benefit to KanCare Member	For Members experiencing anxiety and stress, a weighted blanket may help to relieve anxiety and improve deep sleep.
How Members can access this VAB throughout the year	Members request through member services or care coordinator. If they meet qualifications, Member will be sent via mail.

Value-Added Benefits Supporting Healthy Pregnancy and Postpartum Care

In the tables that follow, we describe our VABs that support Members who are pregnant to promote healthy birth outcomes. Each VAB has been designed to keep Members engaged in taking care of their health and the health of their baby during and after pregnancy. These benefits supplement covered services through a combination of incentives for in-home care, virtual apps providing education, peer supports and other maternal care resources.

Babyscripts

Value-added benefit to improve birth outcomes and postpartum health	
Scope and Description	Babyscripts is an adjunct to our Healthy First Steps program and a digital maternity engagement, education and incentive program for Members who are pregnant and new moms. It includes daily educational content on healthy behaviors, baby's development, vaccinations, potential health risks and other topics. It provides in-depth resources on nutrition, exercise, labor and delivery, breastfeeding and more. **Babyscripts is available to Members even if they choose not to enroll in Healthy First Steps.**
Limits or Authorization Requirements	**Limits:** The program ends at 12 months post-delivery. Up to $75 in rewards can be earned on a Walmart Healthy Living e-Gift Card for completing program enrollment and attending specified appointments. **Authorization Requirements:** No prior authorization requirements.
Target Population	Pregnant Members and new moms.
Anticipated Benefit to KanCare Member	Incentive and guidance to get timely prenatal care and learn healthy behaviors during pregnancy and after delivery, leading to improved adherence with recommended prenatal and postpartum visits and improved maternal and child health outcomes.
How Members can access this VAB throughout the year	Members can download the free app from the Apple App Store or Google Play Store. Then they can enroll in Babyscripts to gain access to an app that has information on nutrition, exercise, newborn care, pregnancy stages and more. For assistance at any time, Members can call member services or their care coordinator.

Care Angel

Value-added benefit to improve birth outcomes and postpartum health	
Scope and Description	Care Angel is for Members who are pregnant. Care Angel is an innovative artificial intelligence and voice-enabled nurse assistant that addresses SDOH, care coordination and medication adherence to: ▪ Improve health outcomes and mitigate pregnancy risks ▪ Enhance Member satisfaction ▪ Reduce health care costs tied to inappropriate ED use ▪ Monitors Members (clinical, medication adherence, SDOH)

Value-added benefit to improve birth outcomes and postpartum health	
	▪ Supports inbound and outbound calls
Limits or Authorization Requirements	**Limits:** Care Angel will telephonically deliver one onboarding call and up to two maternity risk trimester assessments and two postpartum outreach calls. **Authorization Requirements:** No prior authorization requirements.
Target Population	Pregnant Members and new moms
Anticipated Benefit to KanCare Member	Improved Member experience through a virtual nurse assistant that helps the Member complete a risk assessment and identifies risk factors that need support during pregnancy and postpartum.
How Members can access this VAB throughout the year	Our member services outbound team (HARC) will refer the Member to engage with Care Angel. Members can call member services for assistance.

First Trimester Prenatal Exam Reward

Value-added benefit to improve birth outcomes and postpartum health	
Scope and Description	To encourage pregnant Members to complete the prenatal exam within the first trimester. Members can earn a $75 debit card that can be used to purchase needed baby items such as pack-n-play, car seat, crib, diapers or other CMS-approved care items.
Limits or Authorization Requirements	**Limits:** Any pregnant Member who completes a prenatal appointment within the first 42 days of enrollment. Claims data or Provider submitted Obstetrics Risk Assessment Form (OBRAF) is used to determine when the reward is issued. **Authorization Requirements:** No prior authorization requirements
Target Population	Pregnant Members
Anticipated Benefit to KanCare Member	Incentive to engage in prenatal care early in order to get them on the right path for a healthy pregnancy.
How Members can access this VAB throughout the year	We contact Members once they are identified as being pregnant. Members can also call member services, their care coordinator or CHW to learn more about this benefit. For assistance, Members can call member services or their maternal care manager.

Healthy First Steps

Value-added benefit to improve birth outcomes and postpartum health	
Scope and Description	Healthy First Steps is an individualized support program for pregnant Members starting with the first trimester of pregnancy and continuing through 12 months postpartum. Through Healthy First Steps, Members receive one-to-one support, pregnancy, post-partum and infant care education and connection to resources. Healthy First Steps helps Members:

Value-added benefit to improve birth outcomes and postpartum health	
	▪ Choose a doctor or midwife for delivery and a PCP for the baby ▪ Schedule visits and exams ▪ Arrange transportation to Provider visits ▪ Connect with community resources or local home visit programs, such as WIC services ▪ Receive family planning information Tools and Education: Our website has tools and educational information such as: ▪ Checklist of items that baby will need ▪ Questions to ask the doctor during pregnancy and after birth ▪ Informative markers of baby's growth before and after birth ▪ Library on topics relevant to pregnancy, birth and more
Limits or Authorization Requirements	**Limits:** The program ends at 12 months post-delivery. **Authorization Requirements:** No prior authorization requirements.
Target Population	Pregnant Members and new moms.
Anticipated Benefit to KanCare Member	Improved maternal and child outcomes by supporting Member's adherence with recommended prenatal and postpartum visits and connecting Members to necessary resources and supports resulting in a better Member experience and birth outcomes.
How Members can access this VAB throughout the year	We contact Members once they are identified as being pregnant. Members can also call member services, their care coordinator or CHW to learn more about this benefit.

Home Visit Incentive — planned for 2025

Value-added benefit to improve birth outcomes and postpartum health	
Scope and Description	To encourage Members experiencing a high-risk pregnancy to participate in home visit program or our maternal care management program that includes home visits, we are offering a $50 incentive for completing the home visits that are part of the program. In-home care management helps Members prepare for delivery, schedule medical visits and exams and connect with community resources. The reward card can be used to purchase needed baby items such as Pack-n-Play, car seat, crib, diapers or other CMS-approved care items.
Limits or Authorization Requirements	**Limits:** $50 annual reward for high-risk pregnant Members who agree to in-home visits from our maternal care managers, or other Members who engage in-home visits from local community resources. **Authorization Requirements:** No prior authorization requirements.
Target Population	Pregnant Members and new moms.

Value-added benefit to improve birth outcomes and postpartum health	
Anticipated Benefit to KanCare Member	Incentive to receive in-home care and support services for themselves and their baby. Increased maternal care will improve overall birth outcomes and healthier pregnancies and babies.
How Members can access this VAB throughout the year	For assistance, Members can call member services or their maternal care manager will coordinate the home visits.

Lactation Consultation

Value-added benefit to improve birth outcomes and postpartum health	
Scope and Description	Certified lactation counselors (CLCs) support new moms with lactation consultation via video at a time convenient for the mom. Our culturally diverse team includes Black, Latina and American Indian counselors to support our diverse maternal population.
Limits or Authorization Requirements	**Limits:** Members need breastfeeding support. **Authorization Requirements:** No prior authorization requirements.
Target Population	Pregnant Members and new moms.
Anticipated Benefit to KanCare Member	On-demand breast feeding support and education to increase the number of moms who breastfeed and the length of time that moms breastfeed.
How Members can access this VAB throughout the year	The Member's maternal care case manager or CHW connects them to a CLC. Also, when Members call our NurseLine or member services, our member advocate or a nurse will connect them to this program.

Nutrition: High-Risk Pregnancy

Value-added benefit to provide nutrition for Members experiencing a high-risk pregnancy	
Scope and Description	When we first learn of a Member's late-term pregnancy, we classify the pregnancy as high risk, which enables us to provide food and deliver it to the home to make sure mom and baby get proper nutrition.
Limits or Authorization Requirements	**Limits:** Member receives up to $145 per month to use toward the purchase of healthy food items via the designated website and supplier, during the last trimester and first month postpartum. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members experiencing a high-risk pregnancy who are engaged in care coordination.
Anticipated Benefit to KanCare Member	Support for moms experiencing a high-risk pregnancy to obtain proper nutrition for themselves and their baby.

Value-added benefit to provide nutrition for Members experiencing a high-risk pregnancy	
How Members can access this VAB throughout the year	Members working with our maternal case workers will be offered this benefit during the care management outreach. Members can also call member services to learn about VABs available to them and be referred to benefits.

Nutrition: SNAP Classes and Reward

Value-added benefit to educate and empower Members to use SNAP benefits for most impact	
Scope and Description	The Create Better Health SNAP Education classes that educators at Kansas State University teach, is made available to Members statewide. Members can attend classes in person or online. The course consists of eight lessons on topics such as food resource management, nutrition and physical activity. Teachers give cooking demonstrations. Members who register and attend the course receive a cooking item of their choice and a food journal.
Limits or Authorization Requirements	**Limits:** Member must complete the course to receive the cooking item and food journal valued at $50 or less. **Authorization Requirements:** No prior authorization requirements.
Target Population	Any Member or family of Member interested in attending the program is eligible.
Anticipated Benefit to KanCare Member	Education on SNAP, which enables them to buy nutritious food to feed their families. We offer this VAB as a reward for completing the course, so parents can learn how to get the most value and nutrition from the foods they bring home and serve to their families.
How Members can access this VAB throughout the year	Members can contact member services, their care coordinator or CHW who can direct Members to register for the classes.

Pack ‘n Play

Value-added benefit to improve birth outcomes and maternal health	
Scope and Description	**New in 2024: Members who fill out an attendance form at a community Baby Shower will receive a Pack ‘n Play worth $75.** Community baby showers are held throughout the year at community-based locations such as Hiawatha, Kansas City, Topeka, Emporia, Pittsburg and Junction City, among others. Many of the community-based organizations that support or host the community baby showers are social service resources for the Member after the pregnancy. These events are for pregnant and new mothers to learn about health and wellness for themselves and

Value-added benefit to improve birth outcomes and maternal health	
	their babies. We collaborate with a community partner to present health education to attendees.
Limits or Authorization Requirements	**Limits:** When they attend a baby shower, Member will receive a Pack 'n Play. **Authorization Requirements:** No prior authorization requirements.
Target Population	Open to Members who are pregnant, their partners and other family members who can attend events to learn about healthy pregnancies and healthy babies.
Anticipated Benefit to KanCare Member	Education and resources on health and wellness for mothers and their babies. Connection to community resources that can help them to be healthy and get health care and social support services before, during and after pregnancy. The additional incentive of a Pack 'n Play promotes safe sleep for the baby.
How Members can access this VAB throughout the year	Members are invited via letters from our community partners and event flyers. We give flyers to Providers who share them with Members. At the shower, attendees can: ▪ Ask questions and learn about early prenatal care (at events we provide education and awareness on prenatal and postpartum care) ▪ Get information on various community resources available to support their pregnancy ▪ Sign up for our Healthy First Steps program

Wellhop

Value-added benefit to improve birth outcomes and postpartum health	
Scope and Description	Wellhop is a virtual support group for Members who are pregnant. We offer this service because it is critical to have a good social support network when one is pregnant. Through Wellhop, Members can share their difficulties, get guidance from a trained group leader and learn from each other. Wellhop brings expecting parents together with similar due dates in group video conversations throughout their pregnancies and after birth. The program includes the following: ▪ Group video conversations with a trained facilitator and Members at the same stage in pregnancy ▪ Evidence-based information on pregnancy and postpartum, educational articles, videos, podcasts and more ▪ Convenient access from mobile devices ▪ Access to online community 24 hours a day, seven days a week
Limits or Authorization Requirements	**Limits:** Members participate during the second and third trimesters and up to four months postpartum.

Value-added benefit to improve birth outcomes and postpartum health	
	Authorization Requirements: No prior authorization requirements.
Target Population	Pregnant Members and new moms
Anticipated Benefit to KanCare Member	Connection with other parents through video conversations every other week, hosted by a trained group leader. Expected outcomes include the following: ▪ Decreased preterm births ▪ Reduced cesarean section rate ▪ Decreased rate of low birth weights ▪ Improved HEDIS® measures ▪ Increased Member satisfaction
How Members can Access this VAB throughout the Year	Members can download the free app from the Apple App Store or Google Play Store. Members can call member services for assistance.

Value-Added Benefits Support Targeted Populations with Specific Needs

In the tables that follow, we describe our VABs that support Members who have a specific need tied to their health condition, age or where they live. Each VAB has been designed to expand on covered services to support overall health.

Adult Dental Care

Value-added benefit to promote improved overall health for our adult Members	
Scope and Description	Members receive an additional $500 in coverage for specialty dental services KanCare does not cover. This could be used to help cover a portion of the cost for services such as special X-rays, dentures, oral surgery and root canals.
Limits or Authorization Requirements	**Limits:** Up to $500 per year per Member and services must be provided by a network dental Provider to be covered. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members aged 21 and older. **Note: The Adult Dental Care VAB is important to our KanCare Members. Here is a compliment, chosen from the many we receive, expressing the Member's appreciation of this benefit:** "I didn't know with my dental they did fillings this year and someone told me to check, and they did. I now have appointments to get fillings not just pulling them (teeth). I don't think they can make it any better than it is, for me it's perfect. I got to see a dentist for nothing." ***– KanCare enrollee who is a UnitedHealthcare Member***
Anticipated Benefit to KanCare Member	Increased access to dental services beyond routine checkups and cleanings. This is one of most popular VABs among our Members. UnitedHealthcare has offered this VAB since 2019.
How Members can access this VAB throughout the year	Members can call member services to learn about VABs available to them and can be referred to network Providers for services.

Air Purifier

Value-added benefit to help children with asthma breathe better	
Scope and Description	We purchase and ship an air purifier to Members upon request.
Limits or Authorization Requirements	**Limits:** One air purifier valued at $50 per calendar year. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members 18 years old or younger and diagnosed with asthma.
Anticipated Benefit to KanCare Member	Clean breathing environments for children diagnosed with asthma in an effort to reduce risk of asthmatic episodes.

Value-added benefit to help children with asthma breathe better	
How Members can access this VAB throughout the year	Member request air purifier through member services or their care coordinator.

Dining with Diabetes

Value-added benefit to promote health and wellness for Members living with Type 2 diabetes	
Scope and Description	Members diagnosed with Type 2 diabetes or their caregivers can attend Dining with Diabetes classes through Kansas State Research and Extension at no cost.
Limits or Authorization Requirements	**Limits:** One set of classes per Member or caregiver per year. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members with a diagnosis of Type 2 diabetes or their caregivers.
Anticipated Benefit to KanCare Member	Support and education to help mitigate the health effects of Type 2 diabetes.
How Members can access this VAB throughout the year	Members working with our CHWs will be offered this benefit. Members can also call member services to learn about VABs available to them and be referred to benefits.

Medication Lockbox – planned for 2025

Value-added benefit to help safely store medication in the home	
Scope and Description	Provide Members with a medication lockbox to enable the secure storage of medications to limit access to only the prescription holder. The lockbox helps to reduce intentional or accidental overdose, misuse of medications and helps parents to keep their children safe from ingesting medicines. A lockbox will be shipped to the Member's home upon their request, or at the request of their care coordinator or CHW.
Limits or Authorization Requirements	**Limits:** One medication lockbox per household. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members who are enrolled in care coordination, whole-person care, pregnant or certain behavioral health programs.
Anticipated Benefit to KanCare Member	Sense of security and increased safety for Members and families by securing medicines to avoid improper use or accidental overdose.
How Members can access this VAB throughout the year	Members can call member services, their care coordinator or CHW to learn more about this benefit.

Pest Control

Value-added benefit to assist Members receiving HCBS who need help with pest control	
Scope and Description	Pest control treatment of the home provided by a local pest control company. This promotes healthy living in the Member's home.
Limits or Authorization Requirements	**Limits:** Up to $250 per year per household. **Authorization Requirements:** The Member's care coordinator determines the need based on input from subject matter experts**.**
Target Population	Members on a HCBS waiver who own their home.
Anticipated Benefit to KanCare Member	Healthier home living via abatement of pests.
How Members can access this VAB throughout the year	The Member's care coordinator must confirm the need and will plan for the service in collaboration with other staff.

Post-Discharge Meals

Value-added benefit to reduce the risk of readmission following a facility discharge	
Scope and Description	A meal delivery service for Members who have been discharged from an inpatient stay at a hospital, skilled nursing facility or rehab facility and who are at risk for readmission if their immediate nutritional needs are not met. This VAB is available to Members within 30 days of their discharge date to help ease the transition from hospital to home.
Limits or Authorization Requirements	**Limits:** Up to 14 meals, with two meals per day during the first seven days after discharge and Mom's Meals delivers the meals. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members soon-to-be discharged from a hospital, skilled nursing facility or rehab facility who have mobility needs, no family support to assist with food access or who are at risk for readmission due to nutritional issues.
Anticipated Benefit to KanCare Member	Support with food insecurity upon discharge from a hospital stay. Providing these meals reduces the risk of readmission, which in turn reduces associated costs and improves Member engagement in postpartum care for mom and baby.
How Members can access this VAB throughout the year	Our maternal CHWs offer this benefit to Members. Members can also call member services to learn about VABs available to them and be referred to benefits.

School Supplies for Members in Foster Care

Value-added benefit to address health equity and SDOH for kids in foster care	
Scope and Description	A school supply box will be provided to youth in foster care.
Limits or Authorization Requirements	**Limits:** One box of school supplies per child per year. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members who are in foster care.
Anticipated Benefit to KanCare Member	Access to school supplies for foster families and kids in foster care to support successful schooling.
How Members can access this VAB throughout the year	Members contact their foster care agency to receive their school supply box. Members can also call member services to learn about VABs available to them and be referred to benefits.

Tobacco Cessation Member Incentive – planned for 2025

Value-added benefit to incentivize tobacco cessation	
Scope and Description	A $25 gift card that is an incentive for Members to stop using tobacco products. Members who quit using tobacco will receive a gift card for use at a retailer for CMS-approved health items.
Limits or Authorization Requirements	**Limits:** Members who indicate they have quit using tobacco. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members who want to quit tobacco use.
Anticipated Benefit to KanCare Member	Incentive to quit using tobacco and improve overall health and wellness.
How Members can access this VAB throughout the year	Members can call member services, their care coordinator or CHW to learn more about this benefit.

Vision: Eyeglass Frames Upgrade

Value-added benefit to address health equity and cultural diversity	
Scope and Description	Certain waiver populations across the State can receive funds toward the purchase of eyeglass frames not on the list of frames available to Members at no cost.
Limits or Authorization Requirements	**Limits:** Up to $60 once a year. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members aged 21 and over.
Anticipated Benefit to KanCare Member	Opportunity to upgrade to frames in a higher price range than the covered benefit. This addresses Member feedback indicating the frames offered as part of the regular KanCare benefit are not as stylish or sturdy as they desire.

Value-added benefit to address health equity and cultural diversity	
How Members can access this VAB throughout the year	Members can contact member services to learn more about the benefit. They can then work through their vision Provider. Provider services works with vision Providers on how to bill UnitedHealthcare for the frame upgrade.

Value-Added Benefits Promoting Healthy Lifestyles and Wellness

In the tables that follow, we describe our VABs that support Members promote safety and healthy lifestyle choices such as physical activities. Each VAB has been designed to encourage or incentivize Members and their families to be well and live well.

Bike Helmets

Value-added benefit to promote bicycle riding safety for children and youth	
Scope and Description	We purchase and ship a bike helmet to Members upon request.
Limits or Authorization Requirements	**Limits:** One helmet up to $50 in value per Member per calendar year. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members aged 18 and younger.
Anticipated Benefit to KanCare Member	Support for an active lifestyle and bicycle safety.
How Members can access this VAB throughout the year	Members or their caregivers can contact member services or their care coordinator and request the bike helmet. It will be sent to their home via the mail.

Healthy Rewards

Value-added benefit to incentivize Members to get regular checkups and screenings	
Scope and Description	Healthy rewards is a rewards program whereby Members can get a gift card for use at a retailer for CMS-approved health items when they get preventive health services (i.e., well-child visit, annual health assessment, lead screening or chlamydia screening). Members can use rewards to purchase things like clothing, baby products, hygiene products and food.
Limits or Authorization Requirements	**Limits:** Debit card credits between $10 and $25, up to $75 per year. **Authorization Requirements:** No prior authorization requirements.
Target Population	All Members.
Anticipated Benefit to KanCare Member	Incentive to practice good self-care from a young age onward, see their PCP for preventive care and foster strong and lasting Member-PCP relationships.
How Members can access this VAB throughout the year	Members receive rewards after they complete activities such as well-child visits or annual health assessments or close a care gap. In some cases, we coordinate a clinic day with a Provider to close care gaps. Member is invited by mail, email or phone call from us or the Provider office. Members can call member services to learn more about this benefit.

Personal Care Gift Card

Value-added benefit for Members on an HCBS waiver to get CMS-approved personal care items	
Scope and Description	Gift card for Members on a HCBS waiver they can use to purchase over the counter items that CMS has approved, such as healthy food items, first aid, over-the-counter medicine and other personal care items.
Limits or Authorization Requirements	**Limits:** $50 reusable gift card Members can only use to purchase CMS-approved personal care items through approved retailers. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members on HCBS waivers.
Anticipated Benefit to KanCare Member	Support for Members on a HCBS waiver who may not have the financial means to buy personal care items.
How Members can access this VAB throughout the year	Members request through their care coordinator.

Personal Care Gift Card Frontier and Rural

Value-added benefit for Members in frontier and rural areas to get CMS-approved personal care items	
Scope and Description	To support our Members who live in rural and frontier areas of Kansas, we issue a gift card to Members who live in a rural or frontier county. This gift card can be used to order from the online store and have the items delivered to the Member's home or can be used at local dollar stores and Walmart stores across the state.
Limits or Authorization Requirements	**Limits:** This is a reusable gift card Members can only use to purchase CMS-approved personal care items through approved retailers. $50 loaded annually and additional rewards added when the Member earns rewards for healthy activities. **Authorization Requirements:** No prior authorization requirements.
Target Population	Only Members who live in frontier or rural counties in Kansas receive this gift card.
Anticipated Benefit to KanCare Member	Remove barriers to getting personal care items for Members living in frontier and rural areas who may not have the transportation or financial means.
How Members can access this VAB throughout the year	Members can call member services, their care coordinator or CHW to learn more about this benefit.

Reward for Health Screening Tool (HST) Completion

Value-added benefit to incentivize completion of Health Screening Tool assessment	
Scope and Description	An incentive for Members completing the Health Screening Tool whereby Members can get a gift card for use at a retailer for CMS-approved health items when they get preventive health services (i.e., well-child visit, annual health assessment, lead screening or chlamydia screening).
Limits or Authorization Requirements	**Limits:** Debit card credits of $10 per Member per year. **Authorization Requirements:** No prior authorization requirements.
Target Population	All Members.
Anticipated Benefit to KanCare Member	Reward for completing the HST and assessment of the Member's individual needs.
How Members can access this VAB throughout the year	Members receive rewards after they complete a health risk assessment through member services.

Wellness for All

Value-added benefit to encourage and empower Members to live well and be active	
Scope and Description	Members can exercise at facilities of participating organizations in Kansas such as the YMCA or Parks and Recreation locations, or they can opt to receive a fitness kit or outdoor activity ball to use at home.
Limits or Authorization Requirements	**Limits:** One $50 activity, fitness kit or activity ball per year per Member. **Authorization Requirements:** No prior authorization requirements.
Target Population	Open to all Members of all ages.
Anticipated Benefit to KanCare Member	Access to facilities and equipment for exercise and healthy activities.
How Members can access this VAB throughout the year	Members can call member services, their care coordinator or CHW to learn more about this benefit.

Wellness for Kids

Value-added benefit to encourage and empower Members to live well and be active	
Scope and Description	Young Members can exercise at facilities of participating organizations in Kansas such as the YMCA, Boy Scouts, Boys & Girls Clubs or Parks and Recreation locations, or they can opt to receive a fitness kit or outdoor activity ball to use at home.

Value-added benefit to encourage and empower Members to live well and be active	
Limits or Authorization Requirements	**Limits:** One $50 activity, fitness kit or activity ball per year per Member. **Authorization Requirements:** No prior authorization requirements.
Target Population	Open to all Members up to age 18.
Anticipated Benefit to KanCare Member	Encouragement and guidance to live heathy lifestyles. Access to facilities and equipment for exercise and healthy activities.
How Members can access this VAB throughout the year	Members can call member services, their care coordinator or CHW to learn more about this benefit. Many clubs promote this benefit as part of their recruitment efforts.

Value-Added Benefits Promoting Independent Living

In the tables that follow, we describe our VABs that promote independence for Members. Each VAB has been designed to enable Members to address SDOH gaps. VABs address extra transportation, or programs that promote Member independence.

Bus Passes

Value-added benefit to empower Members in gaining independence	
Scope and Description	In addition to the standard NEMT benefit, Members can get bus passes to go to any location on the bus route.
Limits or Authorization Requirements	**Limits:** Up to $25 in bus passes per year. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members aged 19 and older living in Johnson, Sedgwick, Shawnee or Wyandotte County.
Anticipated Benefit to KanCare Member	Increased independence and reduced barriers to public transit.
How Members can access this VAB throughout the year	Members request the bus passes using the same online or call center services as they would to schedule transportation to a doctor appointment.

Educational Advancement

Value-added benefit to help Members become independent	
Scope and Description	Provide funds toward education that can help the Member gain employment, such as GED, coding classes, resumé writing workshops or English as a second language. This benefit provides a support bridge to independence by supporting Members seeking training and education to get or keep a job or advance in the workplace job. Members must go to an accredited school in Kansas for GED and other educational courses will be considered upon request.
Limits or Authorization Requirements	**Limits:** We will fund up to $200 annually for education. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members aged 19 and older Note: In 2025 we plan to lower the age to 16.
Anticipated Benefit to KanCare Member	Decreased barriers to education and support with gaining employment and independence.
How Members can access this VAB throughout the year	Members can call member services to learn about VABs to them and be referred to benefits.

Enhanced Transportation Support

Value-added benefit to address health equity and SDOH	
Scope and Description	In addition to the standard nonemergency medical transportation (NEMT) benefit, Members can get transportation to and from locations where they access SDOH-related services or gain employment, promoting independence. For example, Members can get rides to the pharmacy, grocery store, food bank, WIC, prenatal classes, support group meetings, job-related activities such as interviews, job training, shopping for work clothes or local community activities such as career counseling or early childhood education programs
Limits or Authorization Requirements	**Limits:** Up to 24 round-trip rides per year no more than 10 miles one way. **Authorization Requirements:** No prior authorization requirements.
Target Population	All Members.
Anticipated Benefit to KanCare Member	Increased independence and reduced barriers to accessing community-based, nonclinical services that address Members' SDOH or employment needs.
How Members can access this VAB throughout the year	Members schedule transportation through our NEMT subcontractor (Modivcare) for these extra trips in the same way they would for a ride to a doctor appointment or by calling member services.

Free Mobile Phone

Value-added benefit to enable access to clinical, behavioral health and social services	
Scope and Description	Smartphone with unlimited text, minutes and data, including 25GB high-speed data and 2.5 GB high-speed mobile hotspot data. Members can opt into engagement and outreach enabling health-related campaigns. Members are encouraged to use the device for telehealth with local Providers.
Limits or Authorization Requirements	**Limits:** One device per household. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members 18 years and older.
Anticipated Benefit to KanCare Member	Increased independence, social connectivity and the ability to connect to support services.
How Members can access this VAB throughout the year	The information about this VAB is in the side-by-side comparison the State gives to new enrollees. Members can call member services, their care coordinator or CHW to learn more about this benefit.

Internet Access

Value-added benefit to enable internet access for Members served through waiver programs	
Scope and Description	Covers the costs of internet access for Members in HCBS waiver programs, which enables them to connect with their care coordinator and obtain telehealth services.
Limits or Authorization Requirements	**Limits:** Covers 12 months of internet if Member remains with UnitedHealthcare. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members on HCBS waivers who do not have internet service.
Anticipated Benefit to KanCare Member	Increased independence and ability for Members to maintain choice to remain in their home.
How Members can access this VAB throughout the year	Members request through care coordinator.

Walmart+ – planned for 2025

Value-added benefit to provide delivery service that eliminates the need for transportation	
Scope and Description	Provide Members with monthly Walmart+ membership that provides free delivery from store as soon as same day, free shipping with no minimum order, Walmart reward program, Video streaming on Paramount+ and fuel savings at Exxon, Mobile, Walmart gas stations. This benefit provides home delivery and shipping that eliminates the need for transportation.
Limits or Authorization Requirements	**Limits:** Walmart provides free delivery when the delivery in within 12 miles of the store. This includes Walmart locations across the state border, as long as delivery is within 12 miles of their stores. **Authorization Requirements:** No prior authorization required.
Target Population	Members with mobility issues, chronic conditions or who are enrolled in care coordination, whole-person care, pregnant or certain behavioral health programs.
Anticipated Benefit to KanCare Member	Support with independent living for Members with mobility issues, chronic conditions or other barriers that limit their ability to shop for groceries and other household items.
How Members can access this VAB throughout the year	Members can call member services, their care coordinator or CHW to learn more about this benefit.

Wellness Calendar

Value-added benefit to assist Members enrolled in care coordination to get and stay organized	
Scope and Description	This benefit is a calendar specially designed to help people to track their doctor appointments, medications and social events. Calendars are mailed to Members, usually at the beginning of the calendar year.
Limits or Authorization Requirements	**Limits:** One calendar per household per year. **Authorization Requirements:** No prior authorization requirements.
Target Population	Members who are enrolled in care coordination, whole-person care, pregnant or certain behavioral health programs.
Anticipated Benefit to KanCare Member	This calendar helps Members who have multiple appointments to get and stay organized.
How Members can access this VAB throughout the year	Care coordinators make sure Members receive the calendar and advise them on how to use it.

Quality Assurance (Tab 7e)

Honoring the Community Health Centers Caring for Our Communities

Federally qualified health centers (FQHCs) build healthier communities by meeting critical needs for people who face barriers to accessing health care — including people living in rural and frontier areas. We are dedicated to working alongside FQHCs to advance health equity, build innovative solutions and enhance access to care to improve the health and well-being of people across Kansas.

Kansans United

United Healthcare Community Plan

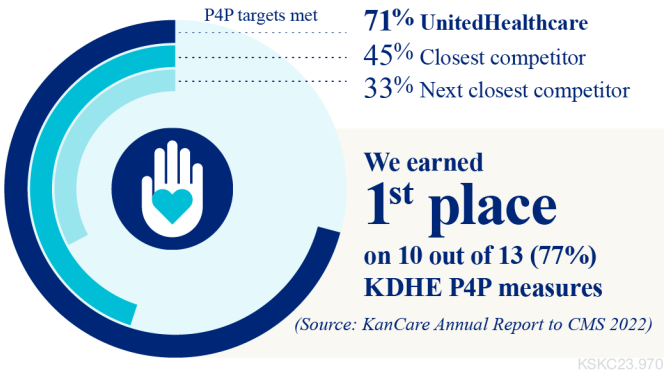
Quality Assurance

19. Describe the bidder's quality program and the bidder's approach to implementing a quality program for KanCare that drives a program-wide culture of continuous quality improvement. Include the following in the bidder's response:

UnitedHealthcare's Quality Management Program

Since 2013, UnitedHealthcare has applied our Quality Assessment and Performance Improvement (QAPI) program to support continuous quality improvement (CQI). Our approach to implementing our market-leading quality program, as we illustrate in the following figure, pairs data, experiences and feedback to deliver demonstrated innovations that impact Members' lives and advance health equity. Annually, we align our population health and quality improvement workplan to priorities in the KanCare Quality Management Strategies. Together these strategies are driving results — UnitedHealthcare has achieved the highest percentage of KanCare Pay for Performance (P4P) targets met every year since 2014 across all KanCare MCOs.

Figure 19-1. Highest % of P4P Measure Targets Achieved



Our Approach to Implementing Our Quality Program

Our Kansas leadership team uses the following three strategies to achieve measurable results and a market-leading QAPI program:

- Use a quality management framework that leads to improved Member outcomes and satisfaction by addressing population health needs and ensuring a feedback loop, led by a dedicated quality team with support from our comprehensive committee structure
- Collect data and information from internal and external data sources of feedback to understand barriers and conduct meaningful performance improvement initiatives on priorities such as P4P measures
- Increase accountability for our performance through our transparency with stakeholders, including our Members, Providers, Kansas Department of Health and Environment (KDHE), Kansas Department for Aging and Disability Services (KDADS) and the Kansas public

To implement our approach, our Quality Management Committee (QMC) establishes and formally documents all aspects of our QAPI program in a trilogy of documents: **the QAPI Program Description, QAPI Work Plan and annual QAPI Program Evaluation**. In the program description, we define goals, objectives, structure, oversight, leadership participation, resources, methodologies (e.g., Plan-Do-Study-Act [PDSA], six sigma and rapid cycle improvement processes) and key components of the quality management program. We develop goals and objectives based on the previous year's evaluation findings and, through direction from our local board of directors (BOD) and our executive team, validate alignment with UnitedHealthcare's strategic plan.

The QAPI Work Plan is the basis for our committee activities and through it we direct routine activities under the quality management

Only 4-Star Medicaid MCO

UHC is the top-rated health plan in Kansas based on NCQA's 2023 Medicaid Ratings

program. We crosswalk KDHE Quality Management Strategy priorities with our annual QAPI Work Plan. The QAPI Program Evaluation, which we prepare in conjunction with the QAPI program annual summary required by KDHE, documents the efficacy and impact of our QAPI program as evidenced by our 4-Star NCQA rating. It is one of the primary inputs to the QMC's development of the subsequent year's QAPI Work Plan.

Driving a Program-Wide Culture of Continuous Quality Improvement

To support KanCare, we demonstrate our values of integrity, compassion, inclusion, relationships, innovation and performance. Quality connects us, because achieving our mission requires striving for excellence in everything that we do. We start CQI by listening with humility to external stakeholders and Members to prioritize topics for improvement. We use data to challenge assumptions to identify root causes and deliver predictable results that exceed expectations. Our Kansas-based leadership team believes that CQI extends beyond the activities of quality management staff to include all our functional leaders and their teams.

Below, we describe how our quality teams reflect these values within our CQI culture:

- **Integrity.** We validate P4P measure data and have collaborated with KDHE to recommend new P4P measures, such as uniform data system (UDS) measures that align with federally qualified health center (FQHC) operations that serve substantial Members for all three KanCare incumbents. We believe doing what is right results in higher levels of satisfaction and better outcomes for Members.
- **Compassion.** Our quality management team completes training on empathy and compassion on an ongoing basis. They volunteer with community-based organizations (CBOs) and identify opportunities for our community reinvestment, such as providing funding to a food bank in Southeast Kansas, which they used to purchase refrigeration. This support increased their capacity to support healthy food access for the entire community.
- **Inclusion.** Quality management staff support our comprehensive programming to identify, address and track Members' social needs to advance inclusion for populations with disparities. In 2023, we added ICD-10 Z codes that identify SDOH needs to our Community Plan Primary Care Professional Incentive (CP-PCPi) program to help encourage Providers' submission of Z codes. Currently, 128 KanCare network Provider organizations participate in the incentive to submit Z codes.
- **Relationships.** Clinical practice consultants (CPCs) are field-based RNs on our quality management team who meet with Providers and their office staff to review performance reports, the associated Clinical Practice Guidelines (CPGs), and to identify opportunities to improve the practice's systems to improve access to care and health outcomes. Our CPCs train and support Provider practices, share reports and answer questions to identify specific opportunities to close gaps in care and earn incentives.
- **Innovation.** Since 2022, UnitedHealthcare's quality management team has donated more than 30 lead analyzer testing devices for use in Kansas Provider offices and county health departments that expands access to lead testing and addresses a barrier to improvement of HEDIS Lead Screening for Children. We expanded on existing relationships with more than 90% of Kansas health departments and share data to drive better outcomes.

- **Performance.** We expanded our Provider incentive pool and implemented a methodology based on the rate of screenings completed to close gaps in care, which led to a 172% increase in total payout of incentives to PCPs between 2021 and 2022, as we illustrate in the following figure.

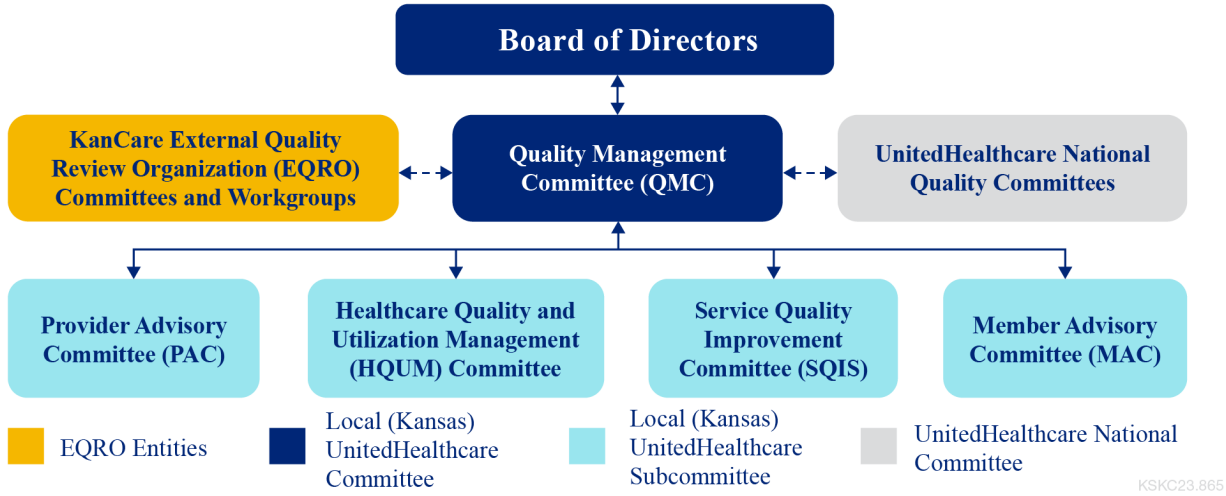
[redacted]

a. The structure, composition, and responsibilities of the bidder's quality-focused committees and how the bidder will use its quality structures to promote changes in plan and Provider practices and operations.

Structure, Composition and Responsibilities of Quality-Focused Committees

We use an integrated approach to our quality structure and oversight, incorporating physical, behavioral and LTSS programs holistically to address care and service rendered across the health care continuum. We have a dedicated local QAPI team led by our senior quality director that facilitates the quality committee structure, development of the QAPI Program Description, the QAPI Work Plan and the QAPI Program Evaluation to meet requirements in **Scope of Services 7.9.1.J**. The ultimate responsibility for the quality program rests with our Kansas board of directors who delegates to our QMC and actively monitors throughout the year. The board of directors reviews and approves the UM and QAPI Program Description, QAPI Work Plan and QAPI Program Evaluation at least annually and we submit to the Kansas Foundation of Medical Care (KFMC) Health Improvement Partners, as required. The board of directors, chaired by our Kansas CEO, meets at least annually.

Figure 19-3. Delegation and Communication in Quality Committee Structure



The QMC structure delineates clear accountability through subcommittee structure and inclusive participation by leaders from all functional areas within UnitedHealthcare. The subcommittees report findings to and make recommendations for approval by the QMC. The QMC has two-way communication with the Kansas external quality review organization (EQRO), including regulatory reporting and feedback. In our KanCare committee structure, we emphasize local leadership with national UnitedHealthcare subject matter expert support. In the previous figure, we outline our quality committee structure, lines of delegation and the flow of information.

In the following table, we define composition, responsibilities and lines of reporting for our quality committee structure:

Quality Committee Structure – Composition and Responsibilities	
QMC **Chair: Chief medical officer (CMO)** **Frequency: Meets quarterly** Composition: ▪ CEO ▪ Medical director ▪ Director of health services ▪ Senior quality director ▪ Quality management representative ▪ Compliance officer ▪ Financial officer ▪ Behavioral health (BH) executive director	▪ Serves as decision-making body with responsibility for implementation, coordination, and integration of all quality improvement activities for the health plan, including allocation of needed resources to achieve the goal of the QAPI ▪ Includes and integrates leaders from all functional areas (e.g., leaders from quality management and improvement, health services, network development, pharmacy, BH, LTSS and special populations, operations and customer service) who are empowered to make or change policies and processes in support of CQI ▪ Oversees the performance and effectiveness of subcommittees ▪ Recommends policy decisions, analyzes and evaluates the results of quality improvement activities, institutes actions to address performance deficiencies and validates appropriate follow-up ▪ Assures integration and coordination of care and service between physical and BH functions ▪ Reviews and approves the QAPI Program Description and Evaluation at least annually ▪ Reports to the board of directors at least annually
Provider Advisory Committee (PAC) **Chair: CMO** **Frequency: Meets quarterly** **Composition:** ▪ Diverse array of Providers based on specialty (e.g., PCPs, specialists, BH specialists and pharmacists), geography, race and ethnicity ▪ Medical director	▪ Evaluates and monitors the quality, continuity, accessibility, availability, utilization and cost of the medical care rendered within our network and performs peer review of network Providers and review and disposition of concerns about quality of clinical care provided to Members ▪ Adopts evidence-based CPGs and UM guidelines and program policies, confirming applicability to the practice of medicine and adherence with the Mental Health Parity and Addiction Equity Act

Quality Committee Structure – Composition and Responsibilities	
▪ Senior quality director ▪ Quality management representative ▪ BH medical director ▪ BH quality manager ▪ BH network representative	▪ Serves as a forum for Provider input on clinical improvement initiatives, clinical guidelines, data analysis, drivers of Member and Provider satisfaction, credentialing, and quality of care (QOC) and quality of services monitoring ▪ Reports to the QMC at least quarterly
Healthcare Quality and Utilization Management (HQUM) Committee **Chair: CMO** **Frequency: Meets Quarterly** **Composition:** ▪ Medical director ▪ Director of health services ▪ Senior quality director ▪ Quality management representative ▪ Compliance officer ▪ UM staff ▪ BH medical director ▪ BH quality manager ▪ BH executive director	▪ Functions as the UM Committee, reviewing and approving the UM Work Plan, UM Program Description and Evaluation at least annually ▪ Reviews UM and pre-service appeals processes, monitoring for efficiency and adherence to turnaround times, including compliance with regulatory and NCQA standards ▪ Implements improvement plans or refers to other committees as necessary to address issues or identified clinical opportunities ▪ Evaluates the integrity of UM decision-making processes through routine review of inter-rater reliability audit reports, recommending improvement actions as indicated ▪ Reviews and approves Kansas' care coordination and disease management programs and monitors program progress and efficacy ▪ Reviews aggregate reports on mortality and other patient safety initiatives and issues ▪ Facilitates integration and collaboration across clinical functions ▪ Reports to the QMC at least quarterly
Service Quality Improvement Subcommittee (SQIS) **Chair: Chief Operating Officer (COO)** **Frequency: Meets Quarterly** **Composition:** ▪ Director of operations ▪ Director of health services ▪ Senior quality director ▪ Quality management representative ▪ Compliance officer ▪ BH executive director ▪ Member services representative	▪ Responsible for the in-depth review and analysis of operations reports and metrics to monitor and improve performance ▪ Monitors access and availability, service quality, complaints, grievances and appeals and other metrics and trends with recommended interventions ▪ Recommends interventions for performance goals based on Member and Provider satisfaction survey results ▪ Facilitates integration and collaboration across operations ▪ Reports to the QMC at least quarterly

Quality Committee Structure – Composition and Responsibilities	
▪ Network management representative ▪ Claims representative ▪ Pharmacy representative ▪ Enrollment representative	
Member Committee: Member Advisory Committee (MAC) **Chair: COO** **Frequency: Meets Quarterly** **Composition:** ▪ A culturally diverse membership that reflects the complexity of Member needs, geography, race/ethnicity, age and disabilities ▪ Director of marketing ▪ Health services director ▪ Senior quality director ▪ LTSS director ▪ Members, families, advocates and CBO representatives	▪ Provides Members and family representatives the opportunity to give feedback on our quality program and our support of the Quality Strategy by encouraging meaningful engagement with Members for improvements to our delivery model ▪ Provides a collaborative forum for Members and their families, community representatives, advocacy groups and community-based Providers to share our successes, self-advocate by bringing issues and ideas, work together on opportunities for community outreach, discuss legislative and regulatory updates, obtain feedback on new and future initiatives and review how these programs fulfill our mission ▪ Advises on opportunities concerning performance related to our service delivery, QOC, Member rights and responsibilities, resolution of complaints, grievances and appeals, operational issues, program monitoring and evaluation, Member and Provider education and any concerns brought forward by participants ▪ Reports to the QMC at least quarterly

How We Use Our Quality Structures to Promote Change

Under the leadership of our CMO and senior quality director, our approach systematically and objectively reviews the performance of our QAPI program to promote CQI. Empowered by the board of directors and described in the table above, our quality committees and local leaders continuously monitor and analyze UnitedHealthcare's and Provider's processes and outcomes, identify areas of improvement and implement strategies for enhancement.

Annually, we formally evaluate and document our QAPI through a trilogy of documents (i.e., the QAPI Program Description, the QAPI Work Plan, and the QAPI Program Evaluation) that help us to establish QAPI goals and objectives and to drive CQI. Incorporating qualitative and quantitative data; clinical service and satisfaction data; and committee actions, the QAPI Program Evaluation from the prior year informs the development of the QAPI Program Description and QAPI Work Plan for the upcoming year.

HQUM Driving Improved Person-Centered Care Coordination Processes

In 2022, through our LTSS compliance quarterly report on our adherence monitoring and audit process, we reviewed findings with the HQUM Committee and received feedback on the action plan to resolve. Our audit tool focused on KanCare contract requirements but did not include all relevant NCQA standards. We revised our audit tool to incorporate contract requirements, HCBS performance expectations, and NCQA standards. **As a result, our adherence audit scores improved from 82% in January 2022 to 97% in September 2023, an 18% improvement.**

UnitedHealthcare Quality Structure Impact on Plan Practices and Operations

Both the board of directors and the QMC review and approve the QAPI Program Description annually, direct its revision as appropriate to the changing needs or strategy, and confirm that the QAPI Program Description includes monitoring and evaluation of care, service and all critical components for a comprehensive quality management program. It defines roles and responsibilities for functional areas to support continued improvement.

EQRO Feedback on Work Plan

"UnitedHealthcare's work plans are well laid out and tie back to the QAPI program description and QAPI evaluation with consistent goals and objectives throughout."

– 2022-2023 UnitedHealthcare KanCare EQRO Technical Report

The QAPI Work Plan is the catalyst — driving changes in policy and process under the quality management program and is the basis for our committee activities. Through quarterly updates and subsequent review and approval by the QMC, we verify that the Work Plan addresses each priority of the KDHE Quality Management Strategy. For example, we establish Member Satisfaction Survey Methodology QAPI goals in our Work Plan to address the State's identified objectives for improved Member care. Our Work Plan addresses the following objectives as a catalyst for change:

- **Promote population health management program activities.** After identifying maternal and infant health as a priority population, we deployed our analytic tools to understand disparities among our KanCare Members. In 2021, the statewide NICU rate was 8.24%; however, Sedgwick County's NICU utilization was 11.27%, driven by disproportionate rates among Black newborns with a NICU admittance rate of 16.5%. Through our Work Plan, we increased care coordination support of pregnant Members and added the advocacy of a doula, **decreasing NICU rates from 16.5% to 9.4% between 2021 and 2022.**
- **Improve Member and Provider experiences.** In 2022, our PAC gave feedback that Provider satisfaction survey return rates were lower than expected. As a result, we have added a $25 incentive for completion of the survey to our CP-PCPi program to increase the completion rate. In 2023, we began using a new vendor for the Provider satisfaction survey with a new methodology that we will track for annual improvements.
- **Adhere to accreditation and regulatory requirements.** Each year in our annual Work Plan, we map objectives to NCQA accreditation standards and use project management tools to track to completion to prepare for triennial accreditation audit. **In our last Kansas health plan accreditation site visit in 2021, NCQA scored us at 133 out of 133 points.**
- **Serve culturally and linguistically diverse populations.** As a result of our annual Member population assessment and determination of Member needs, we identified the need to expand the reach of interpretation services for our Members in Provider settings. We

reached out to clinical partners to learn how to expand the capabilities of their staff. In 2023, we funded the cost of medical interpreter training for 15 current interpreters or bilingual staff who function as interpreters at times in three network FQHCs.

- **Plan-specific objectives.** To measure compliance with KanCare appointment availability standards, our Work Plan includes the review of the Annual Timeliness Report, which we submit annually to the State. This report is an audit of access and availability of Providers in our network to ensure adherence to KanCare guidelines for availability of Members appointments. As a result of our analysis, we have added proactive Provider training to increase appointment availability and update their demographic information in the Medicaid system.

UnitedHealthcare's Quality Structure Impact on Provider Practices and Operations

We continue to put Members — our neighbors and family — first, by empowering and supporting the Providers that serve them through our deep community connections and active engagement. Based on oversight by the QMC, our teams support Providers to improve their practices and operations through various aspects of the quality structure:

- **Provider Relations.** We share resources for Providers to make informed treatment and referral decisions with tools and training on topics such as Health Equity and Cultural Competency and tools such as Comparative Quality and Pricing Information.
- **Pharmacy.** As part of monitoring pharmaceutical UM and quality performance, we offer drug utilization review (DUR) to identify recommended pharmaceutical management for specific Members, narcotic DUR to notify Providers when patients are being prescribed opioids by more than one physician, and a drug safety management program to identify safety concerns for patients. Results of the DUR program are reported into and reviewed by SQIS which is overseen by QMC. From October 2021 through September 2022, we identified 6,413 Members for interventions in our Abused Medications DUR program and sent out letters to their Providers which resulted in a 36% success rate in effecting the desired change in the Member's medication use.
- **Quality Management.** Our quality team empowers Providers at the point of care through supportive tools and data to support closing gaps in care for Members. We locate our five CPCs across the state within the region they serve. As a result, each Provider has a consistent person to contact for quality-related questions — a person familiar with the Provider and their community. Our CPCs conduct regular meetings with Providers to analyze and review quality outcomes, educate Providers on clinical guidelines and HEDIS requirements and improve the practice's systems to improve compliance. Through these collaborative partnerships, our CPCs listen to Providers, learning what education content and format is most helpful. They use a variety of tools and materials, such as our *HEDIS PATH* educational toolkit, to illustrate evidence-based quality performance guidelines for preventive and condition-specific care. Our CPCs deliver gaps in care data in the Patient Care Opportunity Report (PCOR) to Providers and teach Provider staff how to pull their reports from our Provider portal. To increase

> "Pamela (a CPC) has helped us identify the patients who need attention to help provide them with the care they deserve. Pamela has also increased compliance for many of our patients who do not believe it is necessary to come into the office for their chronic care needs."
>
> *– Kansas Medical Associates*

administrative efficiency, we use Point of Care Assist®, a multi-payer integrated electronic medical record (EMR) solution that provides real-time gaps in care information (i.e., PCOR data) by automatically pushing data to Providers system with their approval.

Provider Advisory Committee Feedback - Improving SDOH Support

In 2019, our PAC provided feedback regarding opportunities to identify SDOH gaps during Provider office exams. As a result, we have promoted assessments for Providers to use to identify social needs during office visits. In 2023, we added ICD-10 Z codes that identify SDOH needs to our CP-PCPi program to help encourage Providers' submission of Z codes. Provider adoption of Z code submission allows us to track and analyze SDOH needs at the Member level and statewide level. Going forward, we will monitor and analyze use of Z codes to modify and improve Provider use of Z codes and future program design.

b. The bidder's capabilities to collect and examine quantitative and qualitative data and information to evaluate clinical and LTSS quality, including health outcomes and Member experience, and effective health care operations. Include the bidder's approach to utilizing data, information, and analytics to drive continuous performance improvement.

Our Capabilities for Collecting and Examining Data and Information

At UnitedHealthcare, population health includes reducing disparities. We include three elements to our approach to collect and examine data and information:

- Dedicate a quality management and analytics team who understands KanCare and the needs of Kansans
- Leverage over 40 internal and external data sources to continuously measure, evaluate and improve the services provided to Members over time
- Invest in powerful analytic system mechanisms to collect and perform analytics that focuses on medical, BH, social and equity

Key Outcomes & Key Capabilities

To address local disparities for Black infants requiring treatment from the NICU, we increased care coordination engagement that led to a decrease in the NICU admission rate in Sedgwick County from 16.5% to 9.4% and in Wyandotte County from 12.6% to 8.1% between 2021 and 2022.

These strategies have proven results in Kansas, leading us to achieve the **top-rated Medicaid MCO based on Quality Compass rankings and receipt of the NCQA Electronic Clinical Data Distinction**. To highlight health plans that are leveraging electronic clinical data, NCQA introduced a distinction on their Health Plan Report Cards that identifies health plans using the HEDIS Electronic Clinical Data Systems (ECDS) Reporting Standard. This reporting standard facilitates the use and sharing of relevant electronic data across health care systems. Importantly, it allows for greater assessment of person-specific outcomes, more real-time results and improves the value of information used to assess quality. **We are the only KanCare incumbent with this distinction.**

Our quality management staff collaborates with local and national business intelligence teams to enable efficient and effective data collection and examination. Our local, dedicated business intelligence team consists of four data analysts responsible for KDHE-required reporting who report to our director of operations as well as a director of analytics and reporting who coordinates with KDHE staff on vision and strategy. Our national business intelligence team offers extensive experience in meeting the reporting and data analytics requirements of the

Kansas Medicaid programs. This national team consists of over 100 data analysts who manage the production of reports daily, including custom, scheduled and ad hoc reports.

Together, these teams use multiple data sources and powerful analytic system mechanisms to continuously measure, evaluate and improve the services provided to Members over time. Our robust, integrated reporting and data analytics solution integrates medical, behavioral, pharmacy, financial, demographic and socioeconomic data to produce all the reporting and analytics needed to inform our QAPI, including performance improvement projects (PIPs) and performance monitoring. We report the status and results of each PIP to the State annually, or more frequently as requested by the State or EQRO. The quantitative and qualitative data we monitor and analyze through our scorecards and QAPI Work Plan comes from multiple sources, including:

- **Strategic Management Analytic Reporting Tool (SMART) data warehouse** is an aggregator database for all claims, Member, Provider, pharmacy and vendor data, including vision, dental and state history files.
- **Inovalon NCQA-certified HEDIS software** generates official, final, audited HEDIS measures and Provider profiles and captures data abstracted from medical records during HEDIS hybrid data collection.
- **WEBIZ (Kansas Registry Immunization System)** State's immunization registry is used to supplement administrative and medical record data during data collection.
- **Quality Solutions Platform (QSP)** enables centralized enterprise reporting for HEDIS, allowing for benchmarking and trending.
- **Impact Pro®** provides our team with predictive modeling, evidence-based medicine and tailored clinical and business rules, population risk scores.

We further inform this work with Member, Provider and community insights gathered through our quality committee structure, including our MAC and PAC, as well as community and Provider listening sessions. In addition, feedback is collected from UnitedHealthcare's three independent advisory boards:

- **National Advisory Board** comprises leading experts and aging and disability advocates, UnitedHealthcare Members, and family members of individuals with special health care needs and collaborates on the design and delivery of supports for individuals with special health care needs.
- **FQHC Advisory Board** serves as a platform to elevate Provider voices, advance awareness of successful FQHC practices and work collaboratively toward improving health outcomes.
- **Health Equity National Advisory Board** supports the active engagement of Members, Providers, advocacy groups and other key stakeholders in the design of clinical and organizational practices that reduce health disparities.

Types of Information and Data We Use to Evaluate Clinical and LTSS Quality

We generate more than 200 quality measures across five national measure sets and have the capability to report on over 5,000 measures, sub measures and custom metrics to support effective evaluation of clinical and LTSS quality. In the table below, we list examples of quantitative data and qualitative information that we collect to evaluate health outcomes, Member experience and our health care operations for clinical and LTSS quality. We collect the data sources and information listed below through the SMART data warehouse and view results

through dashboards and report templates. Daily, weekly and ongoing, each functional leader examines assigned operational reporting such as claims, UM, eligibility, and enrollment, to monitor key performance metrics and identify patterns.

Our management team uses a defined schedule of operating review meetings to discuss patterns in analysis, identify actions and make recommendations to the applicable quality subcommittee that addresses clinical and LTSS quality. For example, we conduct a monthly review and trending of internal care coordination audit results (internal chart audits based on NCQA and state standards) and report this information into the HQUM quarterly. Our HQUM Committee reviews the audit results, provides feedback and makes recommendations to the QMC for approval. Our annual evaluation of QAPI Work Plan includes an LTSS-specific quality evaluation.

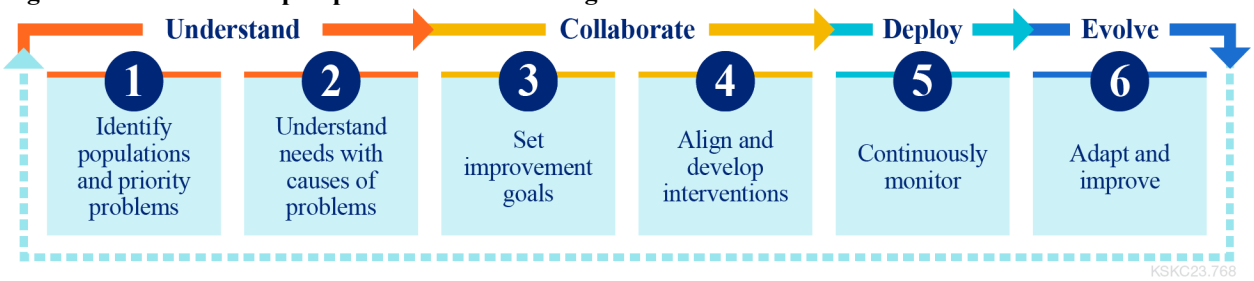
The following table outlines examples of quantitative and qualitative data used to evaluate clinical and LTSS quality.

Data Type	Health Outcomes	Member Experience	Health Care Ops
Quantitative Measures Collected (frequency*) *All measures listed in the table are quarterly unless otherwise noted.	▪ HEDIS, including LTSS, measures (annually) ▪ Effectiveness of care measures ▪ PIPs ▪ Public health and community data ▪ Over- and underutilization ▪ CMS impact measures ▪ LTC over and underutilization report ▪ HCBS performance measures	▪ Adult, Child, and Child with Chronic Conditions, LTSS CAHPS Surveys (annually) ▪ Member services United Experience Surveys (ongoing) ▪ Assessments and person-centered service plans (ongoing) ▪ Key Member Indicator Survey (monthly)	▪ Utilization of Member and Provider incentives and VABs ▪ Chart audit results by health plan and national adherence team (monthly) ▪ HCBS audit results from State partner ▪ Call center data (ongoing) ▪ Credentialing and recredentialing
Qualitative Information Collected (frequency)	▪ CPC meetings with Providers (ongoing) ▪ Monitoring of QOC/QOS ▪ Continuity and coordination of care ▪ National core indicators (AD Survey) (annually)	▪ MAC and PAC feedback ▪ Member complaints, appeals and grievances ▪ HCBS experience survey (monthly) ▪ Experience of care survey (annually)	▪ Clinical medical record review ▪ Delegation oversight ▪ Advisory Board feedback (annually)

How We Use Data to Improve Health Outcomes

Our population health management approach is dynamic, evolving with population outcomes trends, the latest clinical evidence, industry best practices and KDHE priorities. Development and implementation of our PHM approach includes a six-step, data-driven process for high impact PHM that we illustrate in the following figure:

Figure 19-4. Our Six-Step Population Health Management Process



First, we conduct an annual population health assessment in Kansas, which includes an in-depth look of the needs of the KanCare population and prioritize problems. We use information from our population assessments to segment Members into categories aligned with our PHM strategy (e.g., selected age or gender bands, common diagnoses, utilization patterns) and assign risk. We identify priority populations within each segment based on existing data on access to care and health outcome disparities. Second, our root cause analysis allows us to understand the causes of problems. Third, we identify feasible and distinctive improvement goals and develop aligned interventions. Fourth, we implement interventions that address the root causes of problems. Fifth, we set measurable performance thresholds for ourselves and Providers and continuously monitor our performance using relevant, nationally recognized standards — including CPGs, NCQA accreditation requirements, HEDIS measures, CMS Core Measures and CAHPS scores — and internally developed measures, such as severe maternal morbidity and Screening, Brief Intervention, and Referral to Treatment (SBIRT) utilization. Sixth, we assess results of interventions in an iterative quality feedback loop to address in our program evaluation and feed into the next cycle.

How We Use Data to Improve the Member Experience

We evaluate a broad range of sources of data to evaluate the Member experience. For example, we conduct Key Member Indicator (KMI) surveys monthly to derive Net Promoter Scores (NPS), which is a comparison of satisfaction as well as data on key drivers. There is a strong correlation between NPS and CAHPS (0.73 correlation coefficient), so NPS can be used as a leading indicator to CAHPS for ongoing (“constant”) QI focused on experience.

CAHPS. Annually, we conduct an NCQA-certified CAHPS survey to assess overall Member satisfaction and identify and prioritize opportunities for improvement. The CAHPS survey team analyzes and trends the results annually with review by the QMC to identify trends, opportunities for improvement and make recommendations to improve Member experiences. Children with chronic conditions (CCC) represent a relatively small proportion of the overall child population. To achieve enough complete surveys for CCC results to be calculated by NCQA

Top-Rated MCO for 3 of 3 CAHPS Patient Experience Measures

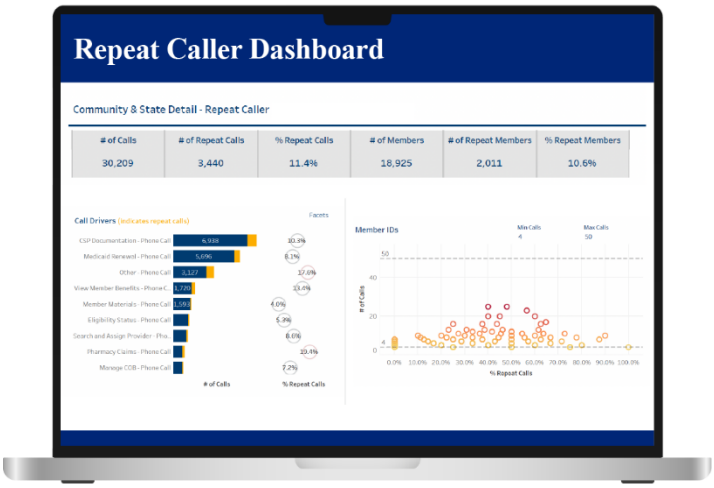
UnitedHealthcare is the top-rated KanCare MCO for 3 of 3 Patient Experience sub-composite measures — Getting Care, Satisfaction with Plan Physicians, and Satisfaction with Plan and Plan Services — and is the top-rated MCO overall with 4 out of 5 Stars in NCQA’s Medicaid Health Plan Ratings, 2023.

standards, a supplemental sample of children who are more likely to have a chronic condition, based on claims experience, is selected and added to the standard CAHPS® Child Survey sample. When reports are delivered, a full report is provided for the combined population (used for NCQA submission), a full report is provided with the child Medicaid results only and a full report is provided with CHIP only results. The protocol satisfies both NCQA submission needs and the needs of CMS Children's Health Insurance Program Reauthorization (CHIPRA) reporting requirements, requested by KDHE. We use CAHPS Member survey results to measure our performance through:

- Establishment of benchmarks and monitoring performance
- Assessment of overall levels of satisfaction to determine whether we are meeting Member expectations
- Assessment of service performance
- Monitoring of access to care

Repeat Caller Dashboard. Repeat calling within a brief period or with the same question or concern indicates that a Member, caregiver or Provider may need additional assistance, or there is a UnitedHealthcare staff training need. The following figure illustrates our Repeat Caller Dashboard. The data source is the call center operations performance data, and we refresh daily with a three-day lag. Supervisors drill down to Member, advocate or call type to pinpoint call repetition cause and to address the issue according to identified scenarios. In addition, we review call drivers, key metrics, and Member survey data (e.g., NPS) during monthly operations and quarterly SQIS meetings. The Repeat Caller Dashboard was a source used to validate that nonemergency medical transportation (NEMT) was an area of focus for Members in the example we describe below of oversight to improve NEMT grievance rates.

Figure 19-5. Repeat Caller Dashboard



How We Use Data to Promote Effective Health Care Operations

Our SQIS reviews quantitative and qualitative data sources to analyze the effectiveness of health care operations and report recommendations to the QMC:

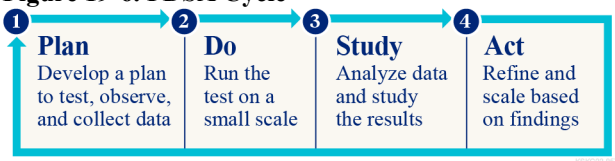
- Review Member and Provider experience results and ongoing improvement activities
- Monitor trends related to Member complaint, grievance and appeal activities
- Monitor trends related to Member and Provider call center activities
- Monitor access and availability results and trends
- Review, approve and monitor Member and Provider service PIPs and activities
- Monitor Provider service measures (e.g., timeliness of claims processing, complaint resolution period)

- Review and approve service-related operational policies and procedures

For example, as part of our vendor oversight process for our vendor, Modivcare, our vendor manager monitors and evaluates NEMT grievance reporting and resolutions. During this process we noticed NEMT Member grievances exceeded the defined service level. To reduce late NEMT grievances, we focused on increasing the Provider network to reduce Provider late and Provider no-shows. We focused on call calibration to make sure accurate information was presented to Members, and we introduced technology solutions to allow Members increased access to their NEMT information. These efforts led to **reduced quarterly average of NEMT grievance rates — from 16.25% in 2021 to 13.0% in 2022 and 4.3% year-to-date in 2023.**

How We Use Data, Information, Analytics for Continuous Performance Improvement

Figure 19-6. PDSA Cycle

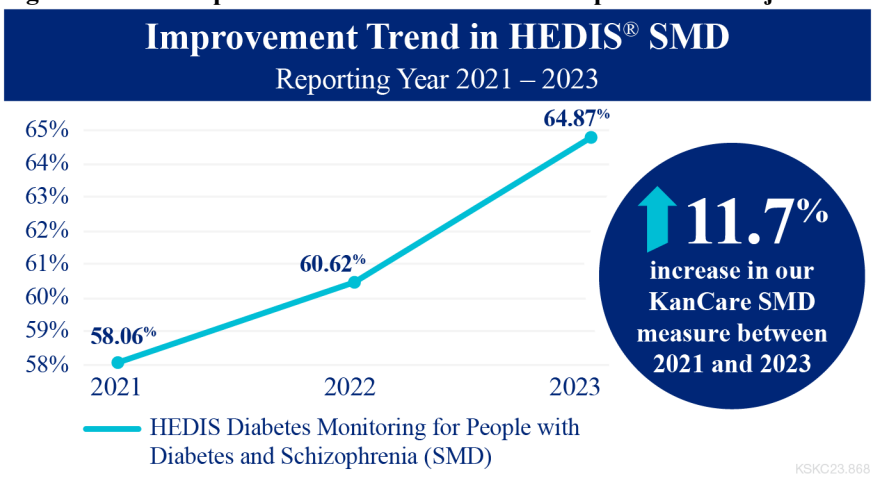


UnitedHealthcare has an established, comprehensive QAPI that continuously assesses performance on measures related to care and service. We use multiple data sources and powerful analytic system mechanisms to continuously measure, evaluate and improve the services provided to Members over time. Each mechanism supports our CQI principles, which focus on the PDSA quality cycle, defined in Figure **19-6**, to meet or exceed the minimum performance standards. This approach includes ongoing monitoring of critical quality indicators, formal PIP measurements and compliance with federal and state regulations and NCQA Health Plan Accreditation standards.

We develop clinical and nonclinical PIPs to drive meaningful improvements in the care and service delivered to Members. At the end of the PIP, we identify successful interventions that can be expanded on a larger scale to achieve the desired health care outcomes. We present regular updates and final project reports to the QMC for review and approval before closing out the PIPs and document all PIP activities in the format required by KDHE/KDADS and submit for regulatory review as required. We report the status and results of each PIP annually, or more frequently as requested by KDHE or the EQRO.

For example, we established a goal of 62.44% in reporting year (RY) 2023 for Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) HEDIS rate. We designed the PIP to improve diabetes testing rates for Members with diabetes and schizophrenia through direct outreach to Members and Providers. We conducted interventions, including targeted outreach to Members who our clinical staff called during semiannual campaigns to encourage them to complete recommended

Figure 19-7. Example of Successful Performance Improvement Project



testing. We sent secure gap-in-care reports to BH Providers and PCPs with a list of Members who were due for their annual HbA1c and LDL-C tests. As shown in the figure above, we achieved hemoglobin A1C (HbA1c) and low-density lipoprotein cholesterol (LDL-C) testing rates of 64.87% in HEDIS RY 2023, exceeding our goal by 2.43 percentage points.

c. The bidder's approach to regularly providing information available to the public about the bidder's program performance in KanCare, including the information the bidder proposes to publicly share and how the information will be shared.

Our Approach to Regularly Providing Program Performance Information

Transparency of performance is fundamental to our quality program. All Kansans should have direct access to be able to evaluate results. As the leader in KanCare quality improvement, we understand that transparency builds trust and fosters a sense of accountability, supports avenues for constructive feedback from stakeholders, which can identify areas for improvement and necessary changes. We believe that transparency allows Members and all stakeholders to make informed decisions. As a result, we share quality information that informs the public and all invested stakeholders of our performance by posting the following reports on our public Member portal (*uhccomunityplan.com/Kansas*) and Provider portal (*uhcprovider.com/Kansas*):

- NCQA Accreditations
- NCQA Health Plan Star Rating
- NCQA Distinctions
- EQRO Report
- Annual HEDIS scores
- Annual CAHPS scores
- Annual Provider satisfaction survey scores

We will create easy-to-understand educational resources that summarize these reports and other QAPI program information in layperson terms using intuitive descriptions. In addition to posting performance data to the Additional Resources page of our public Member and Provider portals, we will promote the sources of performance information and how to access the reports through our *Member Handbook*, *HealthTalk* newsletter, MAC, Provider Manual, Provider newsletter, PAC and regular Provider forums.

Quality Assurance

20. Describe the bidder's experience and approach to improving performance for the following two (2) Healthcare Effectiveness Data and Information Set (HEDIS®) measures in programs similar to KanCare. Include the actions the bidder will take to improve performance on these measures in KanCare and the anticipated improvement for KanCare.

UnitedHealthcare's Experience and Approach to Improving HEDIS® Measures

Highest P4P Outcomes

UHC achieved the highest percentage of targets met every year since 2014, including 71.43% in 2021 (based on the KanCare Annual Report)

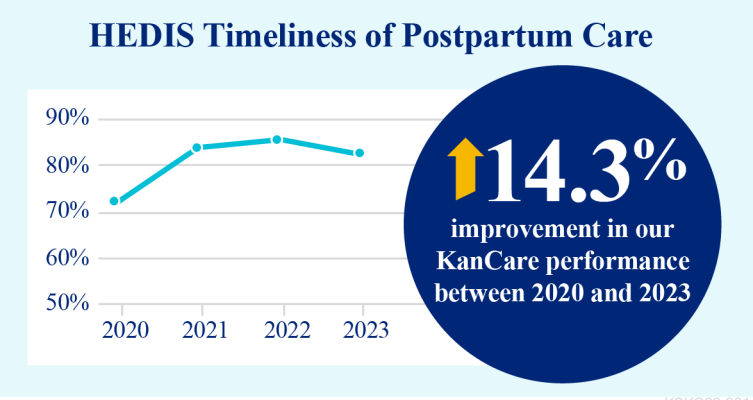
Since 2013, UnitedHealthcare has partnered with KDHE to study root causes of poor outcomes and disparities and implement programs to improve outcomes for KanCare Members. We continuously work to exceed KDHE's established HEDIS® performance targets as described in the figure and sustain meaningful improvement year over year through the implementation of strategies and interventions designed for and in collaboration with our Members, Providers and community stakeholders. Our four-prong approach is led by our local Kansas-based team and leverages lessons learned from other UnitedHealthcare Medicaid plans similar to KanCare:

- Engaging Members to access needed preventive care services
- Collaborating with statewide and local stakeholders to address barriers to Members care
- Collecting and sharing data to submit comprehensive HEDIS datasets
- Educating and incentivizing Providers to understand HEDIS measure specifications and take actions to close gaps in care

a. Timeliness of postpartum care

Timeliness of Postpartum Care Experience

Figure 20-1. Our Improvement Between RY 2020 – 2023



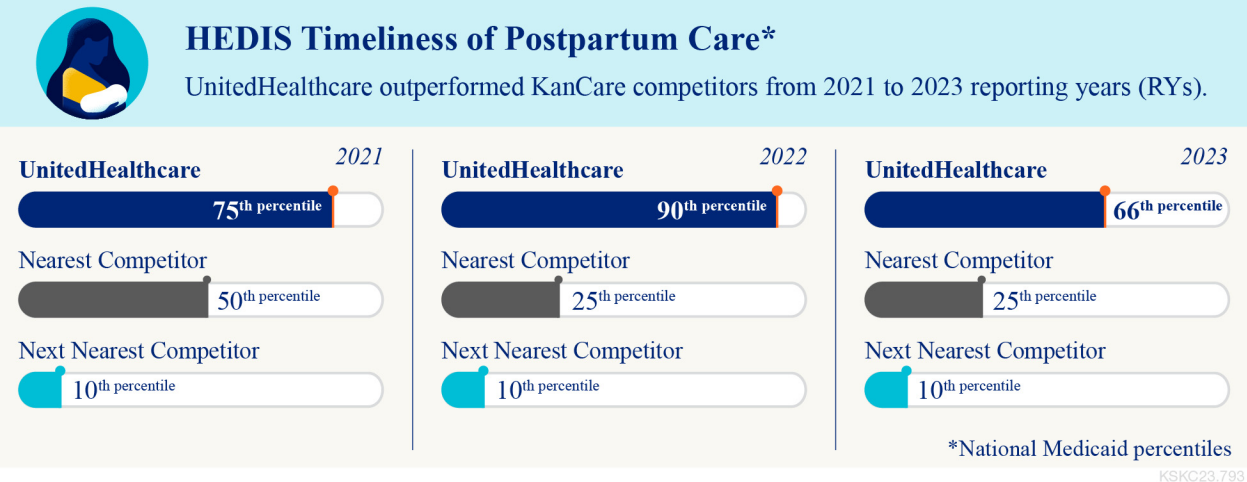
The transition from pregnancy to parenthood can be challenging and comes with associated health risks. From 2016 to 2018 in Kansas, the pregnancy-related mortality ratio (PRMR) was 11 deaths per every 100,000 live births. The leading causes of maternal mortality in Kansas were cardiovascular and coronary conditions, followed by preeclampsia and eclampsia, embolism and infection.[1] Access to timely postpartum care helps reduce maternal mortality. As a result, we enroll pregnant and postpartum Members in our Healthy First Steps (HFS) program, that we describe below, and/or refer them to other

[1] Kansas Maternal Mortality Review Report Highlights. February 2022. kmmrc.org.

appropriate community-based programs which extend support during the postpartum period and lead to improved outcomes.

In Figure **20-1** on the previous page, we demonstrate the success of our approach in the upward trend of performance in Timeliness of Postpartum Care from reporting years (RYs) 2020 to 2023 with a 14.3% improvement over the period. In addition, as we show in Figure **20-2**, we have led KanCare incumbents in Timeliness of Postpartum Care performance over the last three years in national Medicaid percentile that demonstrates our performance leadership in this measure.

Figure 20-2. Leader in Timeliness of Postpartum Care 2021 – 2023



We know our work is not finished. The Index of Disparity for Timeliness of Postpartum Care for Black Members is 6.30 (an Index of Disparity over five is considered high), with the rate for Black Members being 44.1% versus 51.30% for white Members, according to RY 2023 HEDIS data. To improve performance in the Timeliness of Postpartum Care measure, our approach is to deliver local maternity programs to engage Members; collaborate with community-based maternal programs to encourage postpartum visits; collect and share data; and educate and incentivize PCPs and OB/GYN Providers on opportunities to promote postpartum visits.

Engaging Members to Improve Performance in Timeliness of Postpartum Care

Our HFS maternity care coordination program includes postpartum transition planning and support for Members up to 12 months after delivery or as needed, including disease management for high-risk Members (e.g., serious mental illness, substance use disorder, prior pre-term birth and pre-existing/gestational diabetes or hypertension). The program helps Members plan for their delivery and postpartum, prepare for a new baby and offers continuous postpartum assessments and supports. We accomplish this by addressing barriers to care and focus on health promotion, preventive care for the Member and baby and disease management for the entire family. HFS RN care coordination and maternity Community Health Workers (MCHWs) work one-on-one with Members to address barriers such as lack of transportation, childcare challenges and access to covered services, all of which contribute to underutilization of postpartum care. **Nationally, UnitedHealthcare HFS participants demonstrated improved HEDIS Timeliness of Postpartum are by 6.4% (low risk), 5.8% (rising risk) and 6.4% (high risk).**

In addition to our HFS program, we use the following programs and interventions to empower Members to engage in timely postpartum care.

Improving Timeliness of Postpartum Care	
EmpowerHealth	EmpowerHealth is a virtual nurse assistant for Members that complements our care coordination program. Members can opt-in to this program and receive outreach calls that identify and support their needs. Part of this support is outreach that takes place at three and six weeks postpartum. The virtual nurse assistance screens for SDOH needs, BH needs and postpartum complications. Based on those assessments, Members are connected with the adequate supports, such as the HFS team or the NurseLine.
Monthly Postpartum Food Credit	To support high-risk pregnancies, in 2024, we will provide a monthly food credit that will extend to one month postpartum. This benefit will support maternal nutrition, which can directly impact a Member's physical well-being and ability to seek and engage in postpartum care.
Babyscripts™ Mobile Application and Rewards Platform	Babyscripts is a mobile app-based maternity engagement and rewards platform for pregnant Members that drives better adherence with prenatal and postpartum care and targets SDOH. Babyscripts partners with March of Dimes (MOD), the American College of Obstetricians and Gynecologists (ACOG), National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) to combine best practices in maternity care with the latest trends in digital health. Nationally, the rate at which UnitedHealthcare Members enrolled in Babyscripts attend postpartum visits is double compared to non-Babyscripts Members. Also, **Members enrolled in Babyscripts have demonstrated a 127% improved adherence to postpartum visits at 30 days across UnitedHealthcare health plans.** As an enhancement to our rewards program, in 2024, we will begin to automatically distribute gift cards earned by attending postpartum visits based on claims submitted by Providers. The new process will not require Member action, and we anticipate it will increase the volume of Members completing postpartum visits timely and earning rewards.

Collaborating with Community-Based Programs to Encourage Postpartum Visits

Through active listening and our deep community connections, we continue to put Members — our neighbors — first, empowering individuals to thrive. We refer Members in maternity care coordination to community-based programs to provide extended and enhanced support during the prenatal and postpartum periods. The familiarity and trust built within the community-based setting can encourage Members to communicate more openly about their needs and promote adherence to recommended postpartum care scheduled. In the following table, we describe examples of these community programs:

Improving Timeliness of Postpartum Care	
Doulas	In 2022, we partnered with a group of three African American doulas experienced working with their local communities to support African American mothers in Wyandotte County. Doulas help reinforce the importance of the postpartum visit and support the Member by removing barriers to

Improving Timeliness of Postpartum Care	
	scheduling and attending appointments. Through a partnership with The Doula Network, an administrative agency for the pilot, we use technology, administrative support and community entities to lift the administrative burden created by the Medicaid billing process. **Our increased engagement in care coordination and addition of doula support correlated to an increase in Timeliness of Postpartum Care from 42.8% to 44.1% for Black pregnant Members between 2021 and 2022.**
MCHWs – Sedgwick County	We are piloting a MCHW program with the goal of improving pregnancy and birth outcomes and decreasing NICU cost for Members in the Sedgwick County area. Our partner, the University of Kansas Medical Center Research Institute, has hired and trained two full-time MCHWs to provide support and education to participants, as well as assess and address barriers and adverse SDOH. The University of Kansas Medical Center Research Institute in partnership with UnitedHealthcare outreached to key clinical partners to engage them in identifying and referring Members to the program. Members are engaged through community events or other maternal and child programs. Each Member is assessed for educational and social needs, receives culturally competent support and coaching, and is connected to resources to address their needs. Part of the MCHW role is to engage Members in clinical care and make sure gaps in care, like prenatal and postpartum visits, are closed.
MCHWs – Wyandotte County	Our internal- and state-level data show that families in Wyandotte County are at higher risk for negative birth and maternal outcomes. At the beginning of 2022, the Community Health Council of Wyandotte County and the Cradle KC initiative launched a universal maternal and paternal CHW program, the first of its kind in the Kansas City area. In partnership with KDHE, the main funder of this project, we provided funds to increase the number of CHWs supporting this initiative in 2022 and 2023 and continue to support and participate in Cradle KC alongside local health departments, local hospitals and other community organizations. We provide maternal and family welcome bags to support participant engagement, which include items such as lavender oil and lotion to reduce stretch marks, children books and snack containers.

Collecting and Sharing Data to Submit Comprehensive HEDIS Data Sets

We monitor and collect prenatal and postpartum charts throughout the year, so Members receive timely access to prenatal and postpartum care. Below, we summarize the three steps to collect and evaluate data for Timeliness of Postpartum Care.

Receive claims data for maternity services. UnitedHealthcare typically receives global billing claims after delivery. We review global billing claims to understand where Members received prenatal care and get line of sight to where they may receive a postpartum visit. We follow-up on every incomplete Member record to pinpoint where they could make postpartum visits and target those Providers for chart review.

Analyze Member's medical history. Through our data and technology capabilities with the Inovalon HEDIS engine, we flag Members with incomplete claims data, prompting research by

our quality staff. We search for any medical Providers with visits between seven and 84 days after delivery. If necessary, we contact the Member to learn about any recent medical care.

Obtain information not submitted. Once we learn about other visits, we request and review applicable medical records to find missing information and confirm if the visit meets the HEDIS technical specifications for a Timeliness of Postpartum Care visit. We also collaborate and build relationships with Providers to gain electronic health record (EHR) access, which enables us to collect supplemental data year-round to close gaps in care. Through our use of EHR access, we reduce the Provider administrative burden associated with collecting supplemental data. Our data and technology capabilities flag Members with incomplete claims data, prompting our EHR research by our quality management staff.

Educating and Incentivizing Providers to Improve Timeliness of Postpartum Care

We monitor patterns of Provider maternity billing to identify opportunities to educate Providers about KanCare Billing Guidelines. CPCs are field-based RNs on our quality management team who meet with Providers and their office staff to review performance reports, the associated CPGs, and to identify opportunities to improve the practice's systems to improve access to care and health outcomes. Our CPCs use a variety of tools and materials, such as our *HEDIS PATH* educational toolkit which provides detailed information aligned with HEDIS technical specifications that outlines codes associated with the measure, acceptable Provider types, what details are needed as documentation in the medical record and tips and best practices to close this care opportunity. They also deliver actionable gaps in care data in the PCOR to Providers, which includes the due date for the measure and the Member's last known contact information.

Through our CP-PCPi program, participating PCPs and OB/GYNs can earn bonuses for helping our Members become more engaged in their preventive health care. We pay a $50 incentive to Providers for engaging Members to attend a postpartum visit through CP-PCPi. [redacted] an expansion of our Provider incentive pool and we implemented a methodology based on the rate of screenings completed to close gaps in care.

HEPi Focuses on Reducing Disparities in Timeliness of Postpartum Care

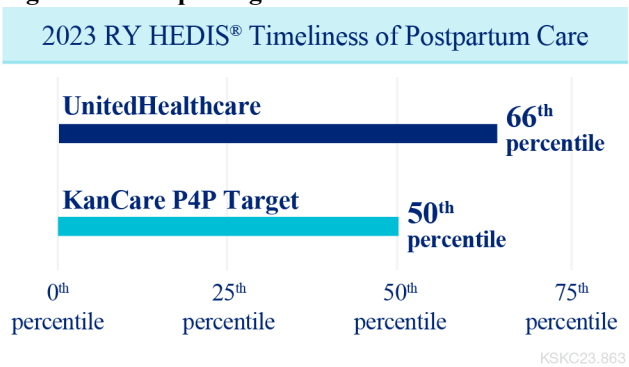
As an example, for our Virginia Medicaid plan, early program estimates for care rendered through the third quarter of 2023 show a postpartum rate of [redacted]

Leveraging the experience of our affiliate health plans. In a 2021 national evaluation of the program, we found that Providers in CP-PCPi achieved 21% higher for postpartum care than Providers not in the program. We also recognized the opportunity to further incentivize postpartum care for Members at higher risk for poor birth outcomes. As a result, we developed our Health Equity Provider Incentive Program (HEPi), which focuses on reducing observed disparities between populations. In 2024, we are expanding our CP-PCPi program to include HEPi for clinics with panels of patients with identified disparity in Timeliness of Postpartum Care.

Anticipated KanCare Improvements for Timeliness of Postpartum Care

In reporting year 2023, UnitedHealthcare continued to exceed the target set by KDHE as we scored greater than the 66th percentile, exceeding the KanCare Pay for Performance (P4P) goal of 50th percentile in national Medicaid data as we illustrate in the figure. While we have exceeded the target, there are opportunities to continue to improve outcomes for pregnant and postpartum Members in Kansas.

Figure 20-3. Reporting Year 2023 Performance



Based on the actions previously described, we will **exceed the KDHE goal and achieve year over year improvement to improve on the 66th percentile of national Medicaid data for Timeliness of Postpartum Care** during the KanCare 3.0 contract period. We will strive to continue to reduce identified disparities in Timeliness of Postpartum Care for Black Members.

b. Lead screening

Lead Screening Experience

UnitedHealthcare strives to meet or exceed the P4P target set by KDHE for Lead Screening in Children (LSC) annually. We constantly pair data, experiences and feedback to deliver evidence-based innovations that truly impact Members lives and reduce disparities to create a more equitable health care ecosystem. Through our experience with KanCare, we understand lead testing, and lead remediation is a complex issue influenced by barriers to care, including SDOH barriers and lack of access to Providers with lead testing devices and administrative barriers associated with meeting the HEDIS LSC specifications. In addition, the Index of Disparity for LSC for Members in rural communities is 6.53 (an Index of Disparity over five is considered high), with the rural rate being 45.1% versus 51.53% for Members in urban communities, according to RY 2023 HEDIS data.

There is no safe blood level in children for lead. To improve performance in lead testing rates and reduce disparities, we use a four-pronged strategy that collaboratively builds and brings solutions:

- Engaging Members, including expansion of access to lead testing
- Collaborating with KDHE and stakeholders to engage parents for testing and data sharing
- Collecting and sharing data for LSC
- Engaging and incentivizing Providers for testing and reporting results

Engaging Members to Improve Performance in LSC

UnitedHealthcare supports the Kansas Childhood Lead Poisoning Prevention Program to increase awareness of the risk and promote prevention strategies to Members, their families and stakeholders in the local communities. Proactively, we send a letter to parents of all Members under the age of two who have not completed LSC to highlight the need for lead testing, and we promote preventive services in our Member newsletter articles regularly. In addition, we share educational and outreach materials such as links from our Member website to the KDHE

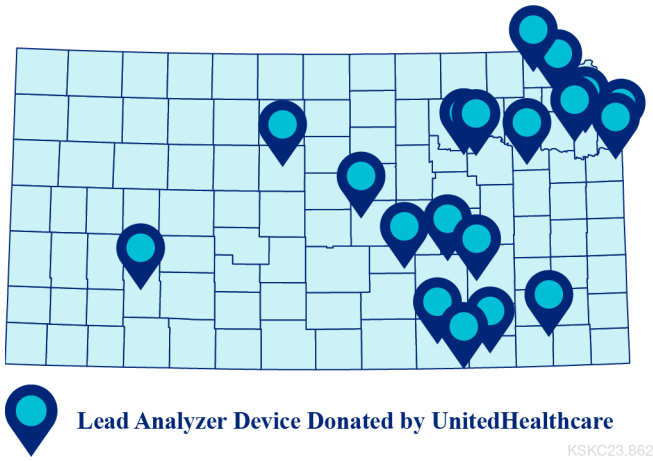
Childhood Lead Screening site that includes resources on lead poisoning prevention, lead exposure management and importance of blood lead testing.

As KDHE sends referrals to UnitedHealthcare for lead testing, our care coordinators outreach within one business day to engage with the family and provide education on lead (e.g., handwashing, nutrition). We assign a CHW for timely follow-up of ongoing lead testing and to assess and address any potential SDOH barriers to completing a lead test such as transportation to the site.

Expanding Access to Lead Testing

Through active listening and deep community connections, we learned that many network Providers, Supplemental Nutrition Program for Women, Infants, and Children (WIC) Providers and health departments would benefit from more lead testing analyzers and a more efficient way for Providers to submit required information with lead results. To address this barrier, since 2022, UnitedHealthcare has purchased more than 30 lead analyzer testing machines and donated them for use in 19 locations across Kansas Provider offices and health departments. This support promotes increased testing for Members in additional PCP and health department locations and helps overcome transportation challenges. To determine where to place the lead analyzer testing machines, we surveyed our Provider network to determine which Providers had point of care testing instruments. If they did not conduct LSC testing, we asked if they were interested in adding this capability. Based on feedback from Members and Providers, we are confident that utilization of lead testing will increase with more convenient locations. The figure maps the locations of additional Providers who now use lead test analyzers due to our funding.

Figure 20-4. Increased Access to Lead Testing



In 2022, UnitedHealthcare started sponsoring mailout test kits to parents of KanCare Members less than two years old through the Let's Get Checked home testing program. Once we receive results of these home tests, we update our HEDIS database and report the test to the Member's PCP. We mailed out 798 lead test kits in 2022, and we tracked a low return rate of completed LSC tests. Our root cause analysis identified an opportunity for a process improvement, and as a result, we enhanced our home testing program to begin sending out kits at the Member's first birthday. This program will allow more time for the parent or guardian to return the results before the second birthday to qualify for HEDIS LSC specifications. In November of 2023, KDHE approved this enhanced lead home testing program which, will begin in 2024.

Collaborating with KDHE and Stakeholders to Engage Parents for Testing and Data Sharing

We actively engage in collaborative workgroups like the Public Health and Medicaid Advisory Group (PHMAG), which addresses a broad range of topics related to lead levels. Through this advisory group, we have developed an understanding of the full Member experience and the challenges stakeholders such as KDHE laboratory, Providers, health departments and WIC

Providers face to increase lead testing. As an example of meaningful collaboration in PHMAG, KDHE has recently begun identifying Members with excessive lead levels and referring for KanCare MCO care coordination. Between August and November 2023, KDHE identified 27 of our Members with blood lead levels of 10 micrograms of lead per deciliter of blood or higher. As described above, our care coordinators outreach to identified families within one business day to engage in care coordination supports. Also, we are developing internal reports using claims data to proactively identify Members with excessive lead levels for care coordination.

Based on discussions with community stakeholders, we believe engagement of subsidized daycare Providers is an innovation to promote the value of lead screening testing to parents of KanCare Members under the age of two. We commit to identifying KDHE-certified daycare locations to promote home tests and nearby PCP locations for testing. We propose to collaborate with KDHE to meet with Kansas daycare centers that the state has certified for subsidized childcare to educate on the importance of lead testing and to share educational materials.

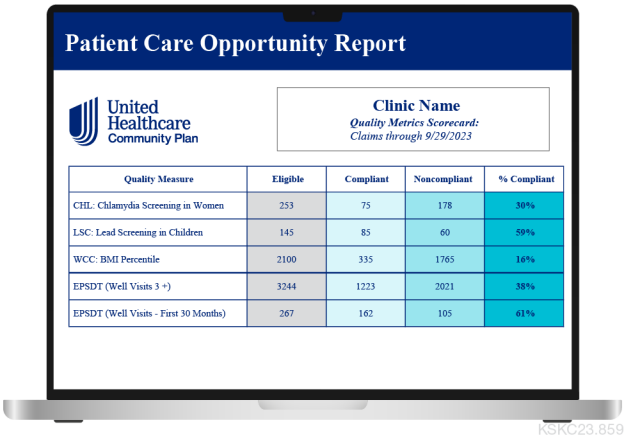
Collecting and Sharing Data to Improve Performance in LSC

Our monitoring of Provider reporting of completed LSC tests for our CP-PCPi incentive program gives insight into the opportunity for increased data sharing between KDHE lab and MCOs. UnitedHealthcare commits to convening a collaborative initiative with representatives of KDHE, WIC, and other KanCare MCOs to continue to address the gap in lead testing data reported to health plans for HEDIS reporting purposes. We will listen in these conversations to learn how to collectively improve LSC rates for all KanCare health plans. We will leverage CQI science to develop a shared understanding of the current flow of test results, conduct root cause analysis to confirm reasons for incomplete testing and identify solutions that support reporting from the KDHE lab and reporting of lead testing from the WIC system. We believe these collaborative efforts can lead to increases in the LSC measure across KanCare.

Engaging and Incentivizing Providers to Improve Performance in LSC

Our CPCs collaborate and train Providers on gaps in LSC using PCOR (our gap in care report), as we illustrate with an example in the figure. In the 2023 HEDIS sample of 411 Member files for LSC, we identified 18 Members as screened but not tested, thereby not meeting HEDIS specifications for the measure. In Provider education sessions, we address the American Association of Pediatrics Clinical Practice Guidelines, distributed by KDHE in the KanBEHealthy Manual, which lists screening or testing for lead levels for patients less than age two. Supporting timely incentive payments and reducing Provider administrative burden, we proactively engage with and educate them about HEDIS specifications (i.e., a test, not a screening).

Figure 20-5. Provider Report for Gaps in Care



In our conversations, Providers have cited reasons for not participating in testing, including the time required to submit documentation for each test result. We commit to collaborate with

KDHE to develop a process to streamline Provider reporting of lead test results. Also, Providers often report their lead testing to the KDHE lab and then do not bill MCOs for the test. In 2021, we began reimbursing PCPs a $150 incentive to send us the lab report created by KDHE, so we can submit the test result for LSC. [redacted]

As described above, our HEPi program focuses on reducing observed disparities between populations. In 2024, we will enhance our CP-PCPi program incentive for lead testing to augment it with HEPi for Provider practices with panels of patients with identified disparity for LSC.

Our Incentive Targeted to Address Disparity for HEDIS LSC Rates

Our Michigan Medicaid plan has found the HEPi program to be effective in improving lead screening rates for Black children who are at higher risk for lead exposure. [redacted]

Anticipated KanCare Improvements for LSC

Based on the actions described above, we will exceed the KDHE goal and achieve year over year improvement in LSC. We have established an improvement goal to **meet and exceed the 33rd percentile of national Medicaid data** during the next KanCare contract period. We will strive to reduce disparities in Lead Screening rates for Members in rural and frontier communities.

Quality Assurance

21. In practice, MCOs have experienced challenges in providing necessary HCBS Waiver services, including those that have been authorized for a Member, creating service gaps. Describe the bidder's approach to identifying and addressing HCBS service gaps to ensure needed services are provided to KanCare Members who are enrolled in an HCBS Waiver and what the bidder will do when Providers/direct care workers are not available to deliver an authorized HCBS Waiver service.

Demonstrated Experience Serving Kansans in All Seven Waivers

UnitedHealthcare has proudly served the State of Kansas (the State) for more than 10 years. We assist over 10,000 Members receiving home- and community-based services (HCBS) waiver services and have 36 years of national experience delivering HCBS waiver services for over 310,000 LTSS Members across 13 states. Today, we provide services for KanCare Members across all seven HCBS waivers. Meeting KanCare Members' waiver services needs starts with offering an accessible, knowledgeable, and diverse network of quality HCBS Providers, including Direct Care Workers (DCWs) with appropriate knowledge and training needed to support Members with complex medical and behavioral health needs. Recognizing a critical gap in DCW availability in Kansas we have best practices and capabilities in place today to identify waiver service gaps, including:

Key Outcomes & Key Capabilities

- We hold **NCQA LTSS distinction** across 13 states with **Kansas exceeding expectations** on audits.
- **92%** of surveyed KanCare Members report **satisfaction with their HCBS care coordination.**
- **98% of Members enrolled on a KanCare HCBS waiver are receiving HCBS.**

- **Monitoring the adequacy and accessibility of our network** through our local provider network team
- **Leveraging data analytics and tools to monitor and understand service delivery gaps** and engaging Members through our **200 local care coordinator staff** to inform personalized and escalated resolution planning
- **Identifying population-level service gaps** through continuous quality monitoring, analysis and action

To address barriers to accessing waiver services we deploy a comprehensive approach that includes:

- Helping Members access their full array of integrated, whole-person care benefits and supports
- Retaining existing Member supports to minimize gaps in services
- Building and investing in HCBS workforce capacity to engage more individuals in effectively providing needed services

UnitedHealthcare commits to investing $1 million annually to grow the Kansas HCBS workforce

Our goal is to improve workforce retention, ensure LTSS quality and support the workforce's well-being. We welcome community and MCO partnerships to jointly use this funding to deliver impactful initiatives.

Approaches to Identifying Gaps in Authorized HCBS Waiver Services

We have comprehensive HCBS service gap identification approaches and capabilities in place that empower our team to successfully identify gaps in authorized HCBS.

Local Provider Team Monitors Network Adequacy and Accessibility

Our Kansas provider network team continually monitors our HCBS Provider network to assess Members' access to care in all 105 counties and serves as an early feedback loop for identifying gaps. **This team has driven our 100% compliance in rural, frontier and urban areas of the State for HCBS contractual requirements.** We submit network adequacy and geographic mapping (e.g., Geo-Access) reports to the Kansas Department of Health and Environment (KDHE) quarterly for review. We proactively review the State Provider File monthly and outreach when we identify a new HCBS Provider. Our team identifies Providers who offer in-home services similar to HCBS and works to recruit them into our network. We also monitor urban versus rural/frontier access to identify disparities in access and monitor out-of-network claims to approach Providers for network participation. We work with Providers submitting HCBS codes about exploring services offered within their contract. After identifying a gap in BI waiver therapy services in Sedgwick County in 2019, we enhanced contract rates with Providers like Minds Matter in Overland Park helping them to expand into Wichita. **From 2019 to 2023, we have seen a five-fold increase in utilization per 1,000 of BI waiver therapy services in Sedgwick County. Minds Matter accounted for over 25% of the increased utilization during that time.**

> "In 2019, we were receiving a higher number of calls from people in Wichita for brain injury waiver services. Kevin Sparks, CEO of UnitedHealthcare, asked us what it would take to expand our services to Wichita because UnitedHealthcare was also noticing a need for our services. Within one year Wichita became, and remains, the area with the highest number of individuals receiving our services on the brain injury waiver."
>
> *– Dr. Janet Williams*
>
> *CEO and founder, Minds Matter*

Leveraging Data Analytics and Tools to Identify Waiver Gaps

For over a decade we have empowered proactive identification and mitgation of service gaps for Members needing HCBS waiver services using data-driven approaches. With the addition of EVV, we have even more timely data to analyze and respond to potential service gaps. Using EVV, satisfaction surveys, claims data and prior authorizations, we have access to a range of daily analytics that inform HCBS capacity and service gaps. Through this suite of analytics-driven reports and through continuous Member engagement we can fully understand Members' needs and identify their service gaps.

UnitedHealthcare HCBS care coordinators monitor service delivery such as for DCWs arriving late or missing a scheduled visit and are trained to leverage their waiver expertise to creatively address Members' needs. Our team monitors HCBS for every Member through monthly telephonic and quarterly in-person (or more frequently based on risk and needs) IDT and person-centered service plan (PCSP) review meetings to verify services are being delivered. We also verify the Member is satisfied with the quantity and quality of their services. HCBS care coordinators are also often made aware of Provider turnover in advance, enabling our team to address care gaps.

Care coordinators and managers also review the following reports to identify HCBS waiver gaps. We discuss anything of concern with the Member at the next touchpoint or immediately if there are safety concerns.

Report Type	Why the Data Matters	Monitoring and Analysis Process
Expiring Authorizations Report	Expired authorizations or delays in providing authorizations can result in a Provider stopping services	Our clinical leadership team reviews this report monthly for targeted care coordinator intervention. When the identified Member does not have an authorization in place at least 30 days prior to expiration, we take immediate action to determine needs and issue the necessary authorization, contact the Provider to confirm receipt, and monitor for service continuation.
Missed Visit Report	When services are not delivered as needed, Members experience a service gap and are at risk for a poor outcome	Care coordinators monitor this report daily and weekly to identify situations requiring immediate intervention. When an instance of missed service/visit is identified the care coordinator engages with the Member and Provider to determine the reason and support resolution.
Authorized Versus Filled Report	Members not receiving all authorized necessary services can result in and admission to a higher level of care	Data in this report is refreshed monthly and provides insights into services utilization. For Members who have a trend in not receiving their authorized services, the care coordinator engages the Member to determine the reason(s) and if there is a change in their condition necessitating a reassessment and adjustment to their PCSP.

We combine this reporting with other indicators into our newly developed HCBS dashboard to make it easy for care coordinators to monitor and identify utilization, worker absences, late arrivals and other service gaps. The following figure depicts a sample HCBS dashboard.

Continuous Monitoring and Analysis Identifies Waiver Gaps and Trends

A key component of our approach to identifying and mitigating service gaps is our commitment to continuous quality improvement. Leveraging our proactive data analytics and detail regarding utilization of services we are able to analyze and segment data to better understand trends at the Member, care coordinator, population and regional levels. Through our Healthcare Quality and Utilization Management (HQUM) Committee; our clinical policies, procedures and processes; Provider and Member education programs and workforce development initiatives are reviewed and informed by identified trends and disparities. Provider and Member survey data, State and census analytics and Provider performance data also inform continuous monitoring.

By serving as a single point of contact for Kansas Department for Aging and Disability Services (KDADS) waiver program managers, our own four full-time HCBS waiver program managers (PMs) receive timely updates about waiver policies and statewide needs across the service spectrum. These staff are a daily resource for our clinical and Member services teams in understanding each waiver's nuances and how to solution for escalated services gaps. Our PMs participate in State

workgroups to review HCBS waiver policies and provide feedback regarding the impact of a proposed policy change. In these workgroups, PMs reflect our Members' and HCBS workforce's voices. The PMs can also easily identify gaps that need to be addressed and communicated back to the State so we may collaborate on waiver innovations. [redacted]

Member Satisfaction

We **administer monthly HCBS Member Satisfaction Surveys** to provide insight into Member experience and to inform our quality improvement initiatives. **YTD 2023, 90% of Members reported they are satisfied or very satisfied with their DCW.**

Approaches to Addressing Authorized HCBS Waiver Service Gaps

We are Kansans fully invested in improving access to HCBS across our state. To address the complex challenges inherent in connecting Members to authorized HCBS waiver services, we work with Providers, Members, the State and stakeholders to continually address authorized HCBS waiver service gaps. Following are some of our key approaches to addressing authorized waiver service gaps.

Helping Members Access Full Array of HCBS, Other Benefits and Supports

Members enrolled in an HCBS waiver participate in a PCSP development process that includes a health screening, health risk assessment, needs assessment and incorporates the Member's expressed and assessed strengths, preferences, person-centered goals and service needs. As we partner with Members to develop and update the PCSP, care coordinators help Members and their care teams understand how to maximize all benefits available to them, including HCBS, state services, community-based organization supports and value-added benefits. This support includes helping Members under the age of 21 access noncovered services available through EPSDT before accessing HCBS. By encouraging Members to optimize all available supports and services we help proactively address gaps in HCBS care. We connect Members engaged in HCBS with services that include but are not limited to the following programs and resources.

My why:

Becky S., MHA, BSW
IDD Waiver Program Manager

"The Kansas IDD waiver has the ability to (and does) serve 9,193 individuals at any given time and there are an estimated 4,500 individuals waiting to access these services. This does not account for others who live with an intellectual or developmental disability who do not even know about the possibility of waiver assistance. We all encounter these individuals in our communities, and unless you specialize, professionals receive very limited to no education to understand how to help one of the state's most vulnerable populations. My why is helping ensure our field staff are prepared and have the resources they need to help Kansans live their healthiest, best lives. As Maya Angelou said, 'My mission in life is not merely to survive, but to thrive; and to do so with some passion, some compassion, some humor and some style.' I'm fortunate to be in a position where I can help supply the tools others need to thrive instead of just survive."

KSKC23.871

CareBridge Helps Reduce Member and Worker Stress

UnitedHealthcare was the first MCO in Kansas to partner with CareBridge, a partner that offers 24 hours a day, seven days a week access to its team of doctors, nurses, social workers and other health experts through Member use of a free digital tablet. While this program does not replace the Member's Providers, CareBridge's team is there when Members need to speak with a doctor, nurse or social worker; order or refill non-narcotic medications; order occupational or physical therapy; get help scheduling doctor's appointments; and/or obtaining durable medical equipment (DME) assistance. By connecting Members with a clinical expert during a critical need we help Members avoid stressful events such as emergency department (ED) visits or inpatient (IP) admissions, both of which often result in Members needing more DCW support. **In partnership with CareBridge, we implemented an expedited DME model that provides Members with empowering alternatives within an average of four days.** DME available through these partnerships includes a dressing stick, sock aid and/or elastic shoelaces to maximize grooming independence and reduce reliance on DCWs.

In Kansas, Members engaged in CareBridge programs experienced a:

- ↓ 10% **decrease** in skilled nursing facility admissions
- ↓ 11% **decrease** in hospital admissions
- ↓ 5% **decrease** in ED visits

KSKC23.939

Partnerships to Address Gaps

Community-based and LTSS partnerships provide our Members with helpful services to remain safely independent in the community. Windsor Place received a SPARK grant from the State of Kansas to pilot its Nursing Home Without Walls program serving selected Members in the Frail Elderly (FE) waiver as of October 2023. **UnitedHealthcare was chosen as Windsor Place's exclusive MCO partner due to our successful nine-year working relationship.** The pilot includes innovative technologies that help address Member independence and safety and reduce reliance on DCWs. As part of the pilot and with Member consent, Windsor Place's care team monitors Members' vital statistics (e.g., blood pressure and heart rate), provides disease and lifestyle education and provides daily Member support through the Vivify Health application.

A Windsor nurse contacts the Member and their doctor if needed. Remote patient monitoring (RPM) capabilities support Members' independence and ability to live on their own terms while ensuring safety via data analytics. Also part of the pilot, Members who elect to participate can access an activity and safety monitoring program. Motion sensors without video or audio are installed (with consent) to monitor movement within the Member's home. For example, door sensors are placed on exit doors and pressure sensors are placed under the bed and on the Member's favorite chair. Artificial intelligence establishes a baseline of Member routines and movements. Windsor Place then contacts our Member when their daily activity patterns change to help monitor the Member's safety.

Leading Rural HCBS Gap Closure

UnitedHealthcare "spearheaded an agreement that addressed and resolved the issues preventing our company from reaching rural areas in western Kansas. If it were not for this innovation, there would be many Kansans who would not be able to age in place in western Kansas."

– Christian Hill,
Chief Executive Office, Thrive Homes

Another partnership (with SmartCompanion) addresses Members' social isolation and helps increase the ability for connections — also reducing reliance on DCWs. UnitedHealthcare's

partnership with SmartCompanion connects Members to SmartCompanion Echo Show technology, increasing Members' community engagement. Echo Show functions as a daily hands-free communication tool and a personal emergency response system. For some, the addition of supportive technology reduces reliance on a DCW in the home and increases independence. **One hundred and four (104) of our KanCare Members have elected to have these devices in their homes.** Partnership with SmartCompanion pairs well with our Windsor Place collaboration to address social isolation support needs. The box below describes how this part of the Windsor Place pilot has significantly helped one Member and his caregiver.

SmartCompanion Echo Device "Makes a Member's Day"

Bradley is a 31-year-old Member on the IDD waiver. He lives with Duchenne muscular dystrophy and has been unsuccessful at using communication devices as he cannot speak loud enough and lacks the muscle tone to use most devices. Bradley has a ventilator which makes it difficult for others to understand when Bradley speaks. Due to challenges related to his diagnosis he cannot call his parents or friends when he wants to and relies on others to do it for him. Our care coordination team provided Bradley with a new Smart Companion Echo device. His mother reported that Bradley taught the Echo his speech patterns in approximately two weeks. She shared that, **"He can tell Echo to call his mom or dad, which he has been unable to do independently in many years. He has been able to call his brother and friends which makes his day!"** With Echo Show, Bradley can now relate to family and friends independently rather than relying on parents or staff to dial a number and hold the phone for him, reducing reliance on caregivers and workers. His mood has improved since receiving the device which he uses daily. Bradley's mother also has less stress knowing Bradley has more independence.

Programs to Help Members Retain and Grow Existing Supports

To connect Members with the care they need to maintain independence, we also focus on helping them strengthen and retain their existing supports. Our approach includes retaining and maintaining informal supports such as family and friends and helping Members maintain DCW consistency. The following programs help Members retain and grow their existing HCBS waiver supports.

Caregiver Supports Increase Caregiver Competencies and Satisfaction

There are approximately 48 million individuals in the United States providing unpaid care to an adult family Member or friend. Research has demonstrated that informal caregivers provide 75% to 80% of total care hours to older Americans living in noninstitutional settings, and 20% of informal caregivers experience burnout. These caregivers provide necessary help for our Members who otherwise would require paid support through DCWs. Therefore, we believe every caregiver that is fully supported is a success. The caregiver is empowered to better help their loved one and Members benefit by receiving care from someone they trust.

Recognizing Kansas caregivers' needs for both educational and burnout prevention tools, we partner with Careforth to provide caregiver support services to nonagency caregivers. Careforth is a market leader with an array of solutions that focus on engaging, empowering and supporting caregivers. Caregivers (who choose this free support) are assigned a personal Careforth coach who provides education on caregiving topics unique to the caregiver. This program's goals are to increase active caregiver engagement in the Member's IDT, increase caregiver confidence and reduce burnout.

Many informal caregivers may also benefit from pursuing education on how to provide support for their loved one. We partnered with a former nonprofit, the QuILTSS Institute, to develop an

online caregivers' curriculum for those who provide services to Members electing self-direction. The curriculum was developed in honor of our LTSS National Advisory Board Member Gary Sullivan, who was a thought leader in championing the importance of supporting caregivers for Members choosing self-direction. We are leveraging partnerships to build out these training modules to make it publicly available to help engage more caregivers in becoming trained to effectively support KanCare Members. Our public-facing caregiver trainings include topics such as dementia and learning to safely manage self-directed tasks, including activities of daily living (ADLs). We are pleased to bring this newly enhanced curriculum to all Kansas stakeholders to further our support for informal caregivers.

Caregiver coaching a success

Nationwide, our Members' caregivers engaged in Careforth coaching experienced **a 37% increase in self-care knowledge, a 32% increase in confidence accessing resources and a 26% increase in navigating the healthcare system** after just six months of coaching participation.

New Proposed Statewide Direct Care Worker Tracking System

DCW experience and consistency are critical to driving Member independence, stability, well-being and quality program outcomes. We are collaborating with Solvative, a digital solutions vendor in Overland Park, to develop an independent statewide DCW enrollment and employment tool that can be used across the State by both Kansas Department for Aging and Disability Services (KDADS) and all Kansas MCOs and agency employers to meet new requirements for tracking DCWs. Since individual DCWs are not enrolled or assigned a State Medicaid ID and are not credentialed, they are essentially "ghosts" within the system and have been, up to now, almost impossible to track.

With UnitedHealthcare consultation and funding, Solvative is creating new technology for a statewide DCW enrollment database to be implemented in collaboration with the State, other MCOs and agency employers. This database will be managed independently by Solvative to ensure conflict free use of this important resource. In this database, DCWs will input their required employment information and their required (and extensive) information for Provider qualifications. When a DCW starts a profile and enters all their contact information, they will choose the services they want to provide and the waivers under which they prefer to work. The system will give Providers prompts based on input to compile information and upload the documentation required to provide those services and work under the waivers they selected. The system will also inform Providers which background checks are required and advise them that those background checks will be completed on their behalf.

Keeping DCW employee files current and in compliance with CMS regulations is very difficult and has resulted in corrective action plans for agency employers and the State. **This tool offers multiple benefits for Kansas waiver stakeholders, tracks all requirements and sends 90-day advance reminders to appropriate parties** when it is time to renew background checks, upload a new driver's license, or any other periodic requirement built into the database. When individual DCWs do not keep their employment profile current, they will be marked as ineligible to work under HCBS until their profile is again current. This tool will encourage DCWs to maintain compliance while also supporting DCWs by hosting an electronic employment file that contains their required employment information and information for Provider qualifications, which will be made

available to any agency or Financial Management System (FMS) Provider across the State who employs the DCW. It also functions as an auditing resource for the agency or FMS Provider as it tracks Provider qualification requirements, sending reminders to the employer that it is time to renew DCW background checks or any other periodic requirement.

Building HCBS Provider Capacity

Another strategy we use to continually address gaps in authorized HCBS waiver services is to build Kansas' HCBS Provider capacity. Our central priority is to build and sustain an accessible, caring, trained HCBS network that delivers quality and timely services to all KanCare Members. To address Provider shortages, we develop unique Provider contracts to expand services. Contracts often leverage pay-for-performance and value-based payment arrangements. We also invest strategically in the Kansas HCBS workforce, including our commitment to provide **$1 million annually to grow the Kansas HCBS workforce.** Building Provider capacity requires a focus on maintaining the existing caregiver infrastructure while identifying new caregivers to fill the growing need for DCWs. We welcome stakeholder feedback into the following strategies for building HCBS Provider capacity.

Investment in Workforce Development: In 2022, we provided $100,000 in investments to Wichita State University's (WSU) online Direct Support Professional Badge Courses Program. This program provides basic knowledge of skills to become direct support professionals. WSU has enrolled 42 apprentice candidates thus far. Going forward, we will collaborate with Kansas HCBS stakeholders, community colleges and trade schools, and the Kansas Board of Regents (KBOR) to develop and help fund a curriculum specifically tailored to DCWs (inclusive of DCWs, certified nursing assistants and home health aides) who work in an HCBS setting. As part of this collaboration, we will partner with HCBS Provider agencies to develop specific strategies to be incorporated into the curriculum to help address problematic issues related to burnout or turnover in the HCBS workforce. This curriculum will ideally include intern or "shadowing" hours with a current DCW for real-life experience and exposure to working conditions. We will partner with KBOR to implement the planned DCW curriculum at the same time across the State so it will be widely available to help keep pace with the HCBS workforce shortages. Proposed curriculum will prepare graduates for the diverse settings and circumstances they will encounter in their jobs, including different home settings, individual family dynamics and safety issues. Training will include strategies on mitigating challenges, defusing conflicting input from family Members and making job safety a priority.

Sustaining Local Provider Partnerships to Offer Timely, Local Solutions: We partner with Providers to develop tailored solutions to address HCBS Provider gaps. To cite one example, in 2023, we developed a contract with Thrive Homes to deliver home modification services and incentivize timely project completion in rural counties east of Sedgwick. We created means for additional payment to be received when a job is started within 42 days of authorization and completed within seven days from the start of the work. This incentive payment is in addition to the Member's lifetime maximum for this benefit and was designed to help offset the upfront costs that may inhibit home modification contractors. This increases Members' access and promotes timely job completion in the eastern half of the state, where locating Providers that can make fast, minor home modifications has been an issue. We continue to pursue innovative contracts like this to incentivize Providers to address gaps in care.

Attracting new Kansas DCWs: Solving for the DCW shortage is a multifaceted endeavor that involves all Kansas healthcare stakeholders. UnitedHealthcare has numerous activities in place today that help address this issue. We briefly highlight these in the below table and look forward to continuing our work to grow the DCW workforce.

Capability	Description
Promoting Self-Direction	Self-direction allows Members to receive care from someone they trust and can significantly increase the pool of available workers. We partnered with Applied Self-Direction, a national consultant specializing in the latest best practices in self-directed care to evaluate our existing programs and opportunities for improvement. Our **Self-Direction Community of Practice (COP)** engages staff who administer self-direction programs from across the country to discuss relevant topics, including problem-solving approaches. Our health services director and LTSS director are active participants in the COP and use lessons learned from this partnership to enhance staff training on Member self-direction.
[redacted]	[redacted]
Free DCW Matching Service	Through Rewarding Work's platform, the first web-based DCW matching service directory in the nation to focus exclusively on assisting people of all ages with disabilities KanCare Members can connect with DCW job candidates. From 2018 to 2022, we **provided access to 380 Members in Kansas to find and hire DCW support free of charge.**
Self-Direction Toolkit	Through our Applied Self-Direction partnership, we will fund support for Kansas Association of Centers for Independent Living to **update its self-direction toolkit.** The toolkit helps Members understand their rights and responsibilities related to self-direction and the ability to hire their DCW.

Each of these capabilities helps our team attract DCWs in a spirit of collaboration with Members, workers and KanCare stakeholders.

Delivering Services When a Provider is Unavailable

Every available and appropriate service is critical to a Member's ability to live in the community safely with the best quality of life — any service that cannot be delivered is a call for UnitedHealthcare to act. Every Member receiving HCBS has a backup (or contingency) plan in place that anticipates gaps in HCBS and outlines what the Member and their IDT will do in that situation. **Our detailed backup plans were identified as a strength in our most recent external quality review**.

When we become aware of a Provider being unavailable, whether through our digital tools or direct Member engagement, we first evaluate Member risk based on the Member's clinical

needs, services requested and the Member's preferred backup plan. Based on this analysis, care coordinators solve for the gap in service using the Member's backup plan first. We review all services the Member is receiving to understand whether a different service may meet the Member's immediate needs. If this does not address the Provider gap, for Members receiving agency directed services, we contact the agency and discuss options for identifying a different Provider trained and qualified to meet the Member's needs. For Members who choose self-direction, we discuss the option of agency directed care with the Member as an alternative. If the Member chooses to transition from self-direction to agency direction, we work with Provider agencies to access trained, qualified Providers to meet the Member's needs as defined in their PCSP. We have capabilities in place to address longer-term Provider gaps. These include but are not limited to:

- **Offering worker mileage reimbursement** through a single case agreement to support the worker traveling a longer distance to meet the Member's needs
- **Offering an enhanced rate for DCWs** increasing the Provider's and Member's ability to hire qualified workers
- **Coordinating person-centered supports to reduce Member reliance on hands-on care and increase independence** as appropriate (e.g., a Member may prefer to use adaptive equipment to assist with dressing, thereby reducing their reliance on Providers)
- **Enlisting KDADS support to allow nonparticipating Providers to immediately begin serving Members** while expediting contract and credentialing requirements

Going the Extra Mile to Help Helen Remain Safe at Home

Helen is a 29-year-old on the IDD waiver with complex medical needs, including significant muscle weakness, which often keeps her confined to her bed. Helen's agency-directed personal care services (PCS) Provider gave notice they would no longer be willing to provide care to Helen based on risk of injury for caregivers due to Helen's refusal to use DME assistance for transfers. Helen's UnitedHealthcare care coordinator immediately engaged in an extensive search for available caregivers, including offering Providers a significantly enhanced rate. When our care coordinator was unable to find a Provider, she addressed the problem by approaching an area home health agency (HHA) about the possibility of providing PCS. The agency was agreeable but was not yet credentialed with the State as an HCBS Provider or affiliated with a community developmental disability organization (CDDO) to provide IDD waiver services. Our care coordinator escalated the issue, and our team arranged an emergency meeting with the State. **We requested an exception to allow us to pay the HHA** to provide PCS if the agency agreed to start working on their State credentialing and CDDO affiliation. **The State agreed to this exception, and the agency began providing services for Helen within the week**. This support addressed a service gap and empowered Helen to stay safely at home.

Provider Network (Tab 7f)

More than a Ride: Johnson County Collaboration Builds Creative Transportation Solutions

People with intellectual disabilities or behavioral health diagnoses can face barriers to finding and maintaining employment. Our outreach team worked with Johnson County to develop a peer driver program that offers rides to and from work, along with vital one-on-one support. Today, peer drivers complete over 1,000 trips per month, empowering Members while fostering a sense of community.

Kansans United

United Healthcare Community Plan

Provider Network

22. Describe the bidder's approach (including methodology, data used to assess network adequacy, timeline, and use of selective contracting) to developing, managing, and monitoring an adequate, qualified Provider network for the KanCare program. Describe anticipated challenges, network gaps, and how the bidder will address those challenges, including the use of telehealth and other technologies.

For the past decade, UnitedHealthcare has developed, managed and monitored a qualified and adequate network that meets the needs of KanCare Members. We are relentless in our commitment that Members receive high-quality care from Providers of their choice. For eight years, we have been the top-performing MCO for KanCare pay for performance (P4P) quality measures. We demonstrate our ability to comply with **Scope of Services 7.5.2** through creating meaningful and lasting relationships with Providers, understanding our Members' needs, using our comprehensive resources and leveraging innovative solutions. Our member-focused network, which is grounded in Member choice of Providers, is the reason why Members choose UnitedHealthcare during the self-selection process. The foundation of our network lies in our:

- Approach defined by our grassroots, localized principles in following the Member
- Capabilities spanning people, data and our broader enterprise
- Ten years of experience in Kansas and our work across more than 30 states

Through this foundation, we harnessed a new strategy in October 2022 — "Following the Member" — to increase network growth and meet our Members' needs. We used data-driven analytics in a new way to identify and analyze Member utilization patterns, determine Members' preferred Providers, build relationships with Providers and solve for gaps in service. Based on a successful pilot, our refined network development strategy builds off what we have learned and guides us toward a more accessible, qualified and equitable Provider and direct care workforce in areas of Kansas where it is needed most.

In the first 10 months of 2023, we actively recruited nine medical groups, representing more than 90 possible individual Providers with Kansas Medical Assistance Program (KMAP) enrollment. Our efforts added 16 individual physicians, including one pulmonologist, two OB/GYNs and one cardiologist for our rural and frontier network. We are currently working with a Colorado orthopedic group with four outreach clinics in Western Kansas to bring in the hospitals these physicians use for surgeries and procedures.

Testimonial from a Bordering Colorado Provider

"You have helped make this a streamlined and collaborative process on our end to pull the Medicaid and UHC pieces together. It can be a challenge for groups to do business in other states, but so far this has been very straightforward; you have helped make it easy. Communication is always one of the top challenges when working with the insurance companies, and you have stayed on top of that to help us through."

– Mark Welter

Western Orthopedics

Our approach, capabilities and experience are the basis for our network approach and methodology, which includes:

- **Developing Our Member-Focused Network.** Our grassroots approach places the Member at the center of network development and places the Provider's needs and requests at the center of the contracting approach.
- **Using Data to Monitor an Adequate Network.** We use data analytics such as Member care patterns, quality scores and geographic access reports combined with Member and frontline staff to augment our network.
- **Managing and Monitoring a Diverse Quality Network.** Going beyond traditional access measures to confirm adequacy, we implement a comprehensive quality approach to drive Member outcomes.

We live and work in the communities we serve. Our provider relations director has over 30 years of experience supporting Providers in Kansas. Local care delivery insights and established relationships help us address concerns such as reimbursement and administrative simplification, including enabling telehealth and technology solutions to address Member needs and preferences.

Network Approach and Methodology

We are constantly evaluating and adapting our methodology to support continued network growth and Member satisfaction. Change is constant. We are committed to moving faster and evolving as health care and the needs of our Members change. Our detailed network development and monitoring approach follows the Member using the steps:

- **Evaluate:** As we continue to learn from our experience, we evaluate and evolve our network approach using guiding questions to follow and understand our Members' needs, such as:
  - Where are our Members accessing services? Are they visiting Kansas Providers or out-of-state Providers?
  - What is the reach of local health systems? Where are their patients coming from? Where are their patients accessing specialty care?
  - What are the travel and practice patterns of specialists from larger medical hubs, such as Hays and Salina, whose specialists host clinics in rural and frontier counties in Western Kansas?
  - Are there out-of-state health systems conducting clinics in border or Western Kansas counties?
- **Research:** We use searches on county health system websites, claims reporting, internal Provider databases, competitor Provider directories, claims platform contract loads, National Plan and Provider Enumeration System data

Figure 22-1. Following The Member Methodology

files, individual state Medicaid fee schedules and State Provider files to establish a Provider profile. We research Providers to determine where the Providers conduct clinics, the type of services offered and practice patterns. Provider profiles are an internal tool to communicate with and obtain feedback from Providers. Using our research, we develop contracts to meet Provider and Member need, including assisting local health systems in expanding current specialty clinics or adding on-site specialty clinics.

- **Plan Recruitment:** We use our research and comprehensive Provider profiles as the basis for our recruitment list, which actively tracks progress as we engage Providers and welcome them into the network.
- **Conduct Outreach:** We prioritize contacting Providers using our recruitment list and Provider profiles, and we make repeated attempts if necessary. Every call is respectful of the Provider's time and focused on supporting the Provider who already has relationships with some of our Members. We use our Provider profiles to prepare for the conversation, anticipate the Provider's questions and come equipped with answers. Outreach calls build our relationships with Providers in the community as we invite Providers into our network that Members have chosen.

Figure 22-2. UnitedHealthcare Leadership at Fall Provider Conference

KSKC23.704

- **Contract:** We partner with internal colleagues in network development for contract development and execution. Our colleagues are well positioned to help with contracting, due to their history with specific Providers, expertise on rates and contract provisions. A regular discussion topic includes the Kansas Medicaid fee schedule, which is often lower than surrounding states' Medicaid fee schedules. Through our conversations with Providers, we share information on Medicaid and the support we offer. Together, with feedback from the Provider, we determine a proposed rate to match the Provider's impact to the network in terms of expectations, volume, reach and specialty when necessary.
- **Build Relationships:** The UnitedHealthcare leadership team is out in the community, connecting with Providers frequently, including attending multiple Provider association and conferences throughout the year. They meet routinely with Provider associations and federally qualified health centers (FQHCs), like the Kansas Hospital Association, Community Care Network of Kansas and Nursing Facilities Associations. They attend conferences and meetings when available. Our leadership is engaged and wants to hear Providers' feedback on what needs to improve or change, and they actively seek opportunities to obtain purposeful Provider feedback.

Developing Our Member-Focused Network

We listen to and learn from Providers and Members in the community to identify network challenges and collaborate to remove barriers to care. For Providers, we focus on removing barriers to contracting and supporting Providers with personal assistance in navigating

UnitedHealthcare. We are currently contracting with any willing Provider who meets our quality standards. When and if we employ selective contracting, it will be in well-populated areas where our network comprises the highest-quality Providers, such as in metropolitan areas.

Figure 22-3. Positive Provider Experience

Our grassroots approach places the Member at the center of network development and places the Provider's needs and requests at the center of the contracting approach. We connect Providers with a provider advocate and offer to review KMAP enrollment to confirm applications are current, addresses are correct and tax IDs and national provider identifiers (NPI) match claims submissions. In addition, we may request an internal review of the finances and reimbursement possibilities to share with the Provider. Most importantly, we ask the Providers for their input on joining the network, including requests for an enhanced rate or special provisions.

We match out-of-network Providers against the State Provider files to verify enrollment status. In pursuit of network expansion, we contact Providers whether or not they are enrolled with KMAP. After an initial conversation, if the Provider expresses interest in Medicaid, we offer step-by-step assistance to complete KMAP enrollment. We follow the Member by contracting with Providers who our Members are already seeing, and we bring these Providers into network. The benefits are many as we mitigate Provider abrasion, expand access to specialty Providers, minimize Member travel and increase Member satisfaction.

Timeline

As an incumbent, we have an adequate network, and we understand network development is a continuous and evergreen process to make certain our Members have access to the services they need. The following timeline represents the steps moving forward:

2023 Year End

We have conducted a thorough review of nearly a third of rural and frontier counties, and we will focus on reviewing and identifying Providers who need corrections in their Provider profiles for correct reporting or identifying outliers who are not yet contracted. We will continue to research and review Providers who are serving our Members with enough volume to merit outreach.

2024 Activities

- Review 2023 accomplishments, including network growth and adequacy
- Evaluate the Provider experience
- Confirm all Providers are connected to a provider advocate
- Confirm Providers are aware of resources, tools and training opportunities
- Review lessons learned and develop action plan for next steps
- Monitor network adequacy continuously and quality of our network
- Update recruitment list

- Create Provider profiles
- Conduct Provider outreach
- Assess potential for additional network growth
- Evaluate opportunities in respect to 2023 growth, and 2024 network adequacy
- Follow the Member using their preferences and current utilization of out-of-network Providers
- Conduct a county-by-county review of Kansas Providers to confirm inclusion of all contracted Kansas Providers in the claims platform, *Provider Directory* and State network adequacy reporting

2025 and Beyond

Building on 2024, we will complete all activities as listed above. Learning as we go, we will continue to refine our "Following the Member" network approach. We will continue to incorporate State, Member and Provider feedback.

Using Data to Monitor an Adequate Network

We are continuously evaluating and monitoring our network to support network growth, close network gaps and increase Member satisfaction. We use our targeted internal and external resources to assess and monitor network adequacy. In addition to the data-driven tools available to analyze network data, we listen to our Members, Providers, our internal staff and stakeholders to support a network that is Member-centric and Provider-focused. Our goal is to improve access for Members and ease Provider navigation. The Providers' ease of navigation through our processes and systems contributes to increased Provider and Member satisfaction. We use the following network monitoring activities in our ongoing analysis to determine network adequacy described in the following table:

Figure 22-4. Member-Focused Network

Network Monitoring	Description
Geographic Accessibility Reporting	We submit Network Adequacy and Geographic Mapping Reports quarterly to Kansas Department of Health and Environment (KDHE). We provide lists, maps and Provider and specialty counts using the required standards. The network adequacy submission includes network highlights, special projects, challenges and updates on any exceptions outside the accessibility and availability standards.
Member and Capacity Reports	We review Member roster-to-Provider ratio and capacity reports monthly to confirm appropriate Provider capacity and provider panel ratios as defined. To monitor capacity, we use monthly reporting to verify Members are receiving authorized services.

Network Monitoring	Description
Network 360®	Network 360 provides competitive analysis of network access and identifies available Providers for recruitment by type, specialty and geography.
Utilization Data	We evaluate Member utilization using reporting. We monitor out-of-network utilization data for services to determine Provider capacity and evaluate the network to meet Members' needs.
Demographic Data	We stratify and analyze the Member-, Provider- and practice-level demographic data by race, ethnicity, language, age and geography variables. Analysis at this level enables us to identify disparities across Kansas in practice patterns and utilization. Our social determinants of health (SDOH) dashboard displays the distribution of outcomes among subpopulations along demographic features like race, ethnicity, language, gender and geography of residence and the appropriate level of risk.
Advanced Data Analytics	Strategic Management Analytic Reporting Tool (SMART) is our comprehensive, integrated analytical data warehouse that stores all Medicaid relevant information — including claims, Member, Provider and service-specific data. SMART supports quality and performance management and compliance reporting. These components and our experienced reporting team help us meet the State's timeliness and accuracy standards.
Quality Data	Through secret-shopper calls to assess appointment availability and Provider- and practice-level gap in care analyses, our quality team, in partnership with our provider services team, uses data from our Quality Assessment and Performance Improvement (QAPI) program to assess network performance and act on improvement opportunities.
Provider Feedback	We receive feedback in multiple ways, including Provider and town hall meetings, our provider service program and provider grievances**.**
Member and Community Feedback	We review Member feedback to identify specialty types for which Member access is limited. We obtain feedback through our Member Advisory Board, Behavioral Health Advisory Board, town halls, regional collaboratives, focus groups and community outreach and listening, care coordinators, Member grievances related to access and input from community organizations.
Input from Locally Based Staff, Member Services and Care Coordination	Our locally based staff communicate with our provider services team regarding Provider network gaps, including the accessibility and capacity of Providers to meet the needs of Members; the availability and willingness of Providers to serve Members; and how to solve barriers for Members and Providers.

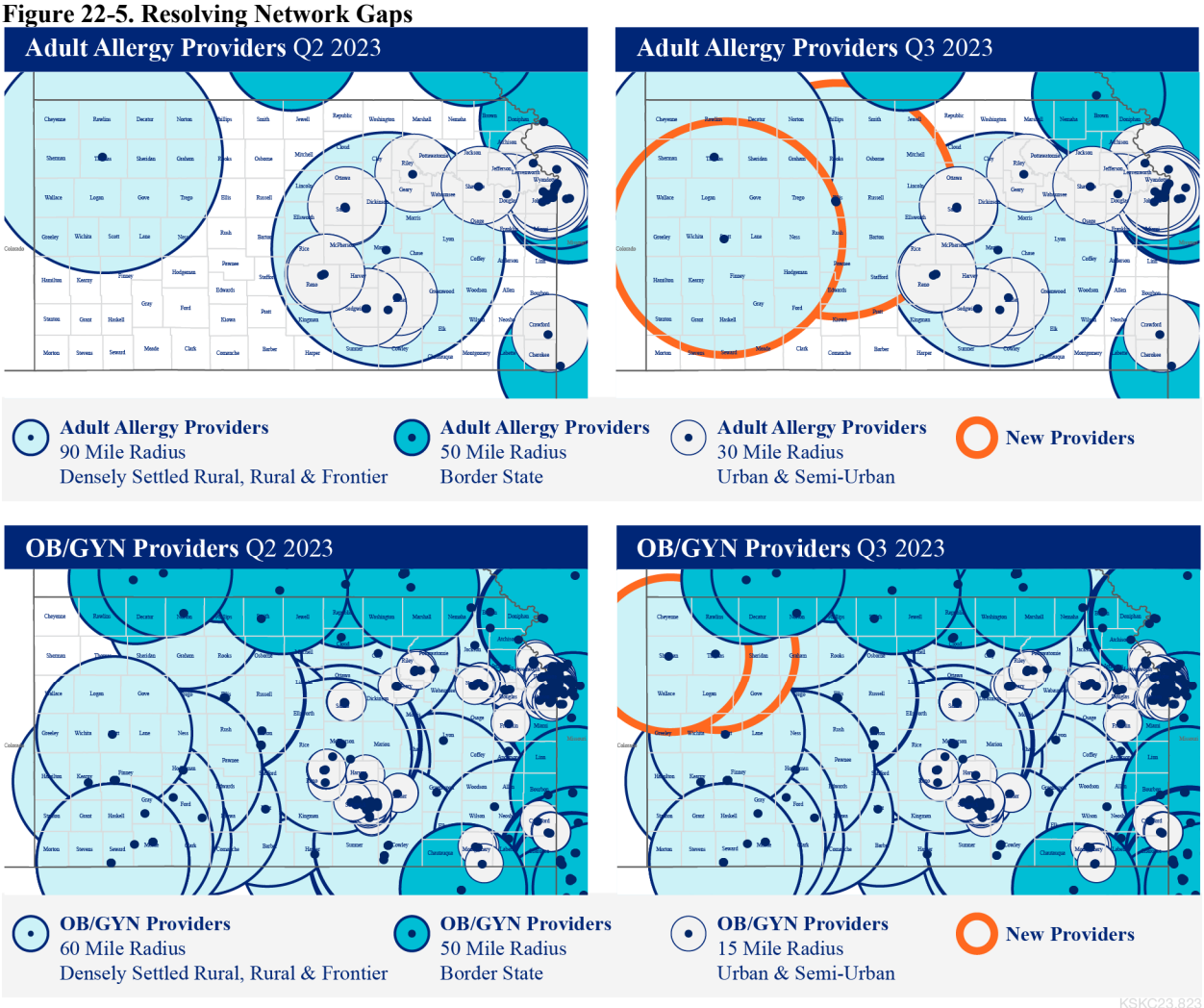
Solving for Network Access Gaps in Kansas

When we identify network gaps, we identify potential Providers to contact to consider network participation. When we cannot identify Providers within the specified time and distance standards in frontier and rural areas, we work with the Member to find the best option to meet

their needs. Depending on the Member's preference, we may connect the Member with a telehealth Provider, cover transportation costs to more distant Providers, or locate a different specialty Provider who can provide appropriate care. Our process for solving for network access gaps includes the following steps:

- **Conduct County-by-County Review:** Our local provider services team regularly performs a county-by-county review of Providers listed as delivering services.
- **Identify Out-of-State Providers:** We identify out-of-state Providers who are enrolled and filing claims without an MCO contracting request using the State Provider file.
- **Review Claims Reporting:** We use our claims reporting platform to identify Member utilization patterns and out-of-network Providers submitting claims.
- **Perform Continuous Research:** We conduct research using Provider websites, Provider databases, Provider reports, competitors' Provider directories and our claims platform.
- **Outreach to Providers:** We contact identified potential Providers based on out-of-network utilization to initiate network participation discussions and perform further analysis to help the Provider decide on network participation if needed.

Figure 22-5. Resolving Network Gaps



For example, in the second quarter of 2023, we identified gaps for Allergy and OB/GYN Providers. Using the methodology and data-driven tools indicated and as shown in the previous figure, we closed the gaps in the third quarter of 2023.

Managing and Monitoring a Diverse and Qualified Network

We manage and monitor our diverse network for KanCare Members by focusing on the Member. We understand building an adequate network is only one component of delivering quality care to our Members. We make sure high-quality Providers are recruited, credentialed and contracted to drive Member outcomes. Our quality approach uses innovative quality programs to confirm program integrity and verify quality Provider data. Our commitment to a diverse and qualified network is demonstrated over the last eight years where we were the top-rated MCO for KanCare P4P quality measures.

Getting Care Easily and Quickly

UnitedHealthcare is the top-rated KanCare MCO in Getting Care Quicky and Getting Care Easily with a sub composite score of 4.5 out of 5 for both categories. UnitedHealthcare was the top-rated plan overall with 4 out of 5 Stars in NCQA's 2023 Health Plan Ratings.

Credentialing, Recredentialing and Contracting

National NCQA Accreditation

UnitedHealthcare holds national NCQA accreditation for our provider credentialing process. NCQA's Credentialing Accreditation is a comprehensive program that evaluates the full operations of organizations providing full-scope credentialing services.

Our network is the foundation to offering quality care to Members in Kansas. We carefully review the qualifications of newly applying and network Providers during credentialing or recredentialing, including education, training, board certification status, license status, hospital privileges and malpractice sanction history. We confirm Providers maintain an active unrestricted license or certification to practice through the State licensing agency using verbal, written or online information. If we find concerns with licensure, we submit the Provider to our Credentialing Committee for further review. We only award contracts to Providers after verifying they meet credentialing and licensure requirements. In addition, we require each Provider to have an NPI, to the extent the Provider is not an atypical Provider as defined by CMS. Network Providers are required to participate in the State Medicaid program, and we verify they are enrolled as an active Provider with KMAP.

We understand the State may be exploring centralized credentialing in the future to standardize Provider enrollment and credentialing processes as outlined in **Scope of Services 7.5.1.A.** We will comply with all established rules, regulations and policies, and we have prior experience in the shared credentialing process. For example, when the Arizona Association of Health Plans (AzAHP) launched an initiative in 2012 to reduce the burden of credentialing placed on Arizona physicians, we participated in the development and deployment of a statewide credentialing alliance, working with other state Medicaid partners as a member of the AzAHP. In addition, in April 2018, our credentialing team implemented processes in conjunction with the Texas Association of Health Plans to implement

"We have had the pleasure of working with UnitedHealthcare since 2019. Our experience has been productive and positive. Communication and credentialing have been a positive experience for our agency. We stay committed and encouraged to continue our professional relationship to serve the children and families in Kansas and meeting their needs with compassion and understanding."

– Holly Creamer, Regional Director
Kansas Behavior Supports

centralized credentialing for Providers. The credentialing verification organization (CVO) is used for Provider credentialing and recredentialing for Texas Medicaid Providers and delivers a streamlined approach for Providers participating in the Medicaid program with other MCOs.

Process timeliness is essential to Members receiving quick access to new network Providers while reducing Provider frustration and payment delays. **We are committing to completing credentialing in 45 days or less and executing and loading network contracts in seven calendar days.** We will create a parallel process for contracting and credentialing so contract discussions and document sharing can occur while credentialing is completed.

Our local home- and community-based services (HCBS) credentialing and contracting team is focused on this critical network and will verify that Providers meet Provider qualification requirements, final setting rules and credentialing standards outlined in the approved CMS waivers. This team is responsible for completing credentialing and contracting in line with all State requirements in addition to confirming compliance for:

- All credentialing rules outlined in each waiver
- All applicable Provider qualifications rules for each waiver both initially and ongoing
- The final settings rule and offer Provider education

Quality Programs

Adequacy in terms of number of Providers and geographic range is essential in developing a network, but it is one component. Validating the quality of our network is a critical element to establishing the best care for our Members. As part of our quality program, we support PCP quality through many supports, including people, training and reporting tools and Provider notifications:

People

- **Access and Availability Network Standards Audits:** At least biannually, the local quality and provider services teams perform this audit to check Provider compliance with these critical contract requirements.
- **Clinical Practice Consultants (CPCs):** CPCs work directly with practices. They distribute Patient Care Opportunity Reports (PCORs) (gaps-in-care reports) to Providers and conduct face-to-face discussions with the Provider to discuss gaps and opportunities to improve quality.

Training and Reporting Tools

- **Health Equity and Cultural Competency Training:** We support Providers in their efforts to advance health equity and provide culturally appropriate care by providing training in health equity foundations, cultural competency and language services to communicate effectively with our Members. Training is available at *UHCprovider.com.* Examples of available training include Health Equity Foundations and Cultural Competency. Providers learn of available resources through the Network Bulletin.
- **Provider Express:** The *Behavioral Health Toolkit for Medical Providers* provides information on screening tools, best practices and referrals, and it includes video (PsychHub) training and resources, including a substance use disorder helpline and clinical guidelines.

- **Comparative Quality and Pricing Information:** We provide an array of online information and decision tools to Providers to assist them in making treatment and referral decisions. These tools include pharmaceutical cost comparisons and quality ratings of network Providers.
- **PCOR:** These reports are available to PCPs via the *UHCprovider.com* provider portal. Providers can access Member lists with identified gaps in care such as immunizations, preventive screenings and well visits.
- **Practice Transformation Support:** We provide a broad spectrum of tools to assist practices and accountable care organizations (ACOs). CPCs work directly with Provider offices and ACOs to assist them in their practice transformation initiatives. They deliver education and tools on the patient-centered care model and address issues, including improving access, avoiding readmissions and improving high-risk patient care.

Provider Notifications

- **Drug Utilization Review Program:** We send Providers letters with recommendations for pharmaceutical management for Members with specific conditions.
- **Narcotic Drug Utilization Review Program:** We send Providers letters when patients are prescribed opioids by more than one Provider.
- **Drug Safety Management Program:** We send Providers letters with recommended pharmaceutical safety concerns.
- **Clinical Practice Guidelines:** At least annually, we review nationally recognized clinical practice and preventive guidelines. Annually, we notify Providers via mail, fax or email of the availability of these guidelines on *UHCprovider.com*.

Program Integrity

Our program integrity (PI) program ties into our overall quality program. During the credentialing process, the PI team conducts routine licensing monitoring for KanCare Providers to verify there are no sanctions, debarments, license issues on State and federal reports or other potential risks to the Member. PI confirms Providers are in good standing and are enrolled with the State, Medicaid and UnitedHealthcare. In addition, PI works with the State on tips and leads on potential fraudulent Providers. Under our PI umbrella, our grievance and appeals team refers quality-of-care concerns to the quality team to determine whether further action is needed.

In addition, HCBS Providers have annual audits as mandated by CMS and the State to confirm they are meeting quality standards and HCBS waivers. We partner with MCOs in Kansas and a trusted audit vendor to verify each HCBS Provider has an annual Provider Qualifications Audit completed as required. We are developing an intensive Provider qualifications education module that Providers will take as given by their assigned provider advocate at least annually to reinforce the importance of compliance with qualification standards each year.

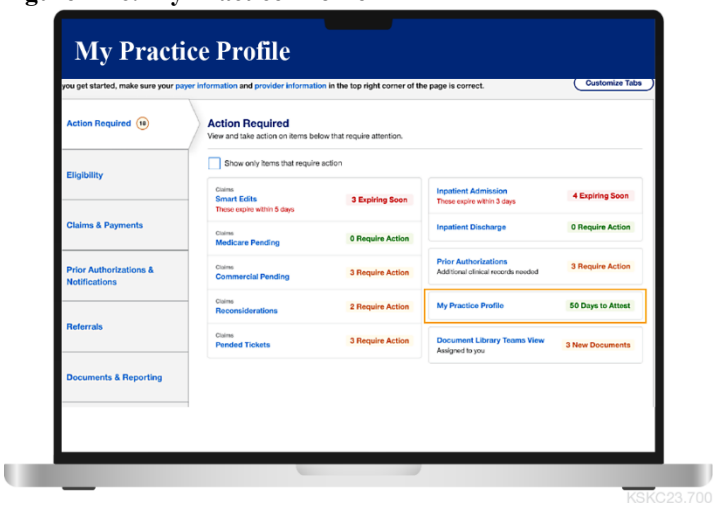
Verifying Quality Provider Data

We have three full-time staff members who are dedicated to auditing and correcting Provider data and work in partnership with quality and claims. We remind Providers of the importance of keeping their contact information up to date with the State and UnitedHealthcare. We provide training to Providers on how to use State tools. In addition, we educate Providers to use My Practice Profile, an online tool on *UHCprovider.com* where Providers can review and update their data for accuracy. Providers are prompted to update their profile quarterly, which is

prominently displayed on their secure portal dashboard each time they log in. Examples of items a Provider can update via My Practice Profile are:

- Ages and Genders Served
- Add and Remove Providers
- Office Hours
- PCP Panel Information
- Accessibility Information
- Demographics
- Practice Information
- Languages Spoken

Figure 22-6. My Practice Profile



Addressing Network Challenges

Using data-driven analytics and information we collect while building and managing our network, we address network challenges, such as access and availability challenges, by applying lessons learned from Providers and Members. As the incumbent, we are prepared and anticipate new challenges as they come our way. The network challenges encountered in the past 12 months and the actions taken are as follows:

	Challenges	Solutions
Reimbursement	Providers are reluctant to join Medicaid networks because reimbursement levels are lower than Medicare and employer-sponsored coverage.	▪ Provider advocates address concerns and provide training to support correct claims processing and maximum reimbursement.
Administrative Burden	Out-of-network Providers sometimes have a negative perception of Medicaid participation due to the level of administrative work required.	▪ To support Providers and encourage network participation, we offer one-on-one support through our provider advocacy team.
Provider Shortage Areas	We are aware of Provider shortage areas in rural and frontier areas.	▪ We are actively identifying out-of-state Providers who serve our Members, and inviting them to join our network. ▪ We are looking to collaborate with rural hospitals that will allow Providers to offer clinics in their facilities to see if they will expand for additional specialty clinics. We are approaching other rural hospitals to offer this as a new revenue stream.

Telehealth and Other Technologies

Due to the changing landscape of health care after the COVID-19 public health crisis, some Members now choose to obtain care from the comfort of their home when needed or appropriate. Members who live in rural or frontier counties often use telehealth as an option to cut down on travel time. Members learn about telehealth options through interactions with member services, our member website and care coordination team.

Where local in-person or tele-enabled Providers are unavailable, we will provide Members the option to engage in virtual care through multiple direct-to-Member telehealth solutions, while synchronizing this care with local Providers through referral and data sharing. With comprehensive telehealth Providers and virtual solutions, we are intentional with coordinating Member care to avoid fragmentation. Through continual monitoring, our team will be intentional about creating an integrated Member experience where telehealth services are coordinated to promote appropriate use and continuity of care. Telehealth Providers in Kansas are licensed in Kansas and state-certified for Medicaid. Options for telehealth in Kansas include:

- **Local Network Options:** Many of our current KanCare Providers have options for Members to see their Provider virtually. We support our local Provider capabilities and promote to Members. The local behavioral health (BH) telehealth footprint has grown 52% year over year with 740 unique Providers offering telehealth as of October 2023.
- **Doctor Chat:** Members can access nonemergent care via an innovative, chat-first platform supported by live video to connect with a doctor from their computer or mobile device. Virtual visits help improve access to care for people in rural areas and Members who have difficulty accessing routine care to maintain their health and stability.
- **AbleTo:** AbleTo is a comprehensive virtual program to support Members with new or ongoing medical conditions and address unmet BH needs, including underlying symptoms of depression, anxiety or stress that interfere with Members' ability to address physical health needs. Members receive treatment from a BH therapist and are supported by a BH coach who provides health education, self-care and lifestyle adaption.
- **Backpack Healthcare:** Backpack Healthcare provides personalized, accessible and inclusive pediatric mental health care to our Members through a self-care app, pediatric and family therapy and family training. Users report less than a five-day turnaround from referral to first appointment, and greater than 60% of patients complete more than 10 sessions.
- **Affect Therapeutics:** Affect's evidence-based digital treatment program for substance use disorders offers effective and intensive treatment to Members who need alternative access to care or Members who prefer treatment outside inpatient or outpatient clinics. Members can access counselors, coaches and medical Providers. We have history with Affect in more than 10 states, where they offer access in a timely manner. As evidence in support of their program, an analysis with the Health Plan of Nevada suggests that their HEDIS® gap closure is significantly stronger than national benchmarks (Initiation of Treatment within 14 days of diagnosis: 44% vs. 79%; Engagement in Treatment: two or more treatments within 34 days: 14% vs. 57%).

Anticipated Network Gaps

We understand the pressing need of HCBS, and we recognize that there are other gaps in Kansas:

- Sedation dentistry
- Medication-assisted treatment (MAT)
- Gastroenterology
- Psychiatry
- Substance use disorder (SUD)

In the fall of 2022, we implemented our grassroots approach of "Following the Member" to recruit and invite their selected Providers to join the Provider network. We piloted our new approach starting in 2020 when we addressed network needs in our autism behavioral analyst (ABA) network. This network was challenging historically due to the limited number of ABA specialists and the training, educational and credentialing requirements for these specialized Providers**. Our persistent approach using research tools available and diligent outreach and follow-up helped grow the network 127% over a period of three years.** As of November 2023, we contracted with more than 50 ABA Agency Providers, and more have expressed verbal intent to join the network. Given our historical success in the ABA network and the progress we have made with the general Provider medical network, we will continue to build on our refined network development approach of "Following the Member."

Continuing to Build the Home- and Community-Based Services Network

Our 10 years of experience in Kansas has brought us deep experience in the HCBS network and expertise in the specific challenges this network brings every day. When evaluating our HCBS network, we use multiple forms of analysis to meet our Members' needs. We track county-by-county membership and prioritize resources needed for access.

We run regular claims reports to identify HCBS codes submitted by volume and frequency. We consult with our care coordination team to determine whether missing HCBS codes are due to lack of Providers offering those services or demand. We talk with Providers submitting those codes about expanding services. We developed Provider contracts to expand services in areas where there is a shortage of available services and Providers. In the summer of 2023, we collaborated with a Provider to develop a contract that incentivized the delivery of home modification services to counties west of Sedgwick County. This contract reimbursed the Provider to provide services in those counties and incentivized the timely completion of projects. This reimbursement allowed the Provider to find and reward workers to complete the project in a timely manner. We will continue to pursue innovative contracts that incentivize Providers in our network and drive workforce development in the HCBS network.

Home- and Community-Based Services Workforce Shortage

In Kansas, there is a severe shortage of direct care workers (DCWs) who provide the HCBS for which Members are authorized. We will deploy **three main strategies** to address challenges in growing an adequate workforce **to provide HCBS** to Kansas Members.

- **Expand training and educational opportunities** for those entering the HCBS workforce
- **Successfully recruit** those graduating from training and educational settings into the HCBS workforce
- **Implement retention strategies** to support DCWs already in the workforce to retain them and others entering the HCBS workforce in the future

Expand Training and Educational Opportunities

Our strategies to expand training and educational opportunities for those entering the HCBS workforce include:

- **Expanding partnerships:** We partnered with Wichita State University (WSU) to implement a supplemental training module for both potential and existing HCBS workers that teaches skills and strategies for task completion and addressing worksite challenges. In addition, UnitedHealthcare provided a grant of $100,000 to WSU to support training, recruitment and retention of DCWs.
- **Using existing resources:** Because development and approval of a statewide specialized curriculum for HCBS-bound workers require time to draft, review, obtain approval and implement by community colleges and technical schools, our short-term strategy is to continue to use existing programs for home health aides (HHAs) and certified nursing assistants (CNAs).
- **Offering specialized curriculums:** We will collaborate with Kansas HCBS stakeholders, community college and trade schools, and the Kansas Board of Regents to develop and fund a curriculum specifically tailored to DCWs (inclusive of DCWs, CNAs and HHAs) in an HCBS setting.
- **Finding new modalities:** We are collaborating with **Solvative** to develop an independent statewide DCW enrollment tool to meet new requirements for tracking DCWs to better manage DCW service capacity and identify gaps in the DCW workforce. In this database, DCWs will input their required employment information and their required (and extensive) information for Provider qualifications. This tool will improve the ability of any organization in the State to track available DCW workforce, service capacity and gaps to maximize the effectiveness of DCWs and help resolve corrective action plans across the State related to tracking the DCW workforce and keeping their employment files and Provider qualifications current.
- **Highlighting resources:** As part of our workforce development efforts to guide students into HCBS-related programs, we will promote the **Kansas Promise Act Scholarship**. The Promise Act Scholarship requires completion of high school (or General Educational Development [GED]) in the previous 12 months, with subsequent completion of a community college or trade school coursework within 30 months of scholarship approval. It can provide up to $20,000 per student for students enrolled in health care coursework, a Kansas high-priority career field.
- **Supporting the Promise Act Scholarship:** We will target students coming out of high school and college-age young adults for potential inclusion in the Promise Act program, sharing the benefits of working as a DCW, including the ability to set their schedule and number of working hours.

Transformative Commitment for KanCare

To successfully implement these strategies, UnitedHealthcare has allocated funding for the next contract cycle in the amount of $1 million per year for investment in initiatives to develop, build and retain the HCBS workforce in Kansas.

Recruitment Strategies

To date, our effort in developing supplemental education and training with WSU has been independent of the other MCOs in the state. However, since the shortage of HCBS workforce is a statewide issue, we will **convene a workgroup with other KanCare MCOs** to form a unified marketing and recruitment effort to attract and recruit HCBS workers into the workforce, since all Kansans will benefit from an influx of DCWs. In concert with other KanCare MCOs, we will contribute funding for shared recruitment staff — staff that will engage with and connect DCWs

to the HCBS staffing agencies. Together, we will hire a marketing firm to deploy a standard marketing campaign and a social media campaign to achieve maximum saturation.

We will distribute expenses evenly across the three MCOs, including recruitment staff costs and associated marketing and travel costs. We have already participated in multiple meetings and workgroups with other MCOs and the Department of Education to collaboratively develop and promote a clear job path for the HCBS workforce. These collaborations have informed our immediate, short-term and long-term strategies to address HCBS workforce shortages. In addition, the State established the creation of an Advisory Committee in which all the MCOs and other stakeholders will participate. We have supported the State in chairing a quarterly Financial Management Services Committee meeting and would be happy to chair and run the Advisory Committee on behalf of the State and the other MCOs or support the State in additional roles.

Retention Strategies

With many parnterships and programs in place, we will continue to support DCWs already in the workforce to retain them and others entering the HCBS workforce in the future.

- **Careforth Partnership:** We partner with Careforth to deliver caregiver support services to non-agency caregivers, which includes both informal supports and paid family caregivers. Caregivers are assigned a coach who provides education on caregiving topics through an approved curriculum and is available to discuss caregiving concerns unique to the caregiver. The program's goals are to increase active engagement in the Member's care team, increase caregiver confidence and reduce caregiver burnout.
- **CareBridge Support:** CareBridge is another resource to support both Members and DCWs providing services to the Physically Disabled and Frail Elderly waiver populations. DCWs can contact CareBridge through the push of a button on a tablet provided to the Member by CareBridge and UnitedHealthcare. CareBridge staff can help address concerns or offer guidance designed to support the Member's desire to remain in their home.
- **Nursing Loan Repayment Program:** We are implementing a nursing loan repayment program for individuals graduating from a nursing curriculum. After a nurse completes one year of service in the HCBS field on either the Kansas Technology Assisted (TA) waiver or the Intellectual and Developmental Disability (IDD) waiver, UnitedHealthcare will pay $12,000 toward that nurse's student loan(s) to incentivize nurses to work in the HCBS field.

Provider Network

23. Increased demand for HCBS and Behavioral Health Services has created challenges in ensuring an adequate workforce to provide HCBS and Behavioral Health Services. Describe the bidder's approach for addressing workforce development challenges for HCBS and Behavioral Health Services.

UnitedHealthcare's Approach for Addressing Workforce Development Challenges for HCBS and Behavioral Health Services in Kansas

We will deploy four main strategies in Kansas to address challenges in ensuring an adequate workforce to provide HCBS to our Members. These four overarching strategies span the full continuum of efforts required to:

- Streamline tracking of the existing HCBS direct care workers (DCW) workforce for the benefit of all stakeholders
- Expand training and educational opportunities for those entering the HCBS workforce
- Successfully recruit those graduating from training or educational settings into the HCBS workforce
- Implement retention strategies to support DCWs already in the workforce to retain them and others entering the HCBS workforce in the future

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We understand that in addition to the workforce challenges for HCBS services, there are Behavioral Health (BH) staffing barriers to address. Our approach to overcoming these BH challenges involves a three-pronged strategy:

Transformative Commitment for KanCare

To successfully implement these strategies, **UnitedHealthcare has allocated funding for the next contract cycle in the amount of $1 million per year** to be invested in initiatives to manage, develop, build and retain the HCBS workforce in Kansas.

- Expand our existing BH network, including workforce development investments
- Maximize the capacity of our existing network
- Deploy technological solutions to fill remaining gaps

In the following paragraphs, we describe how we will deploy these strategies in Kansas to overcome HCBS and BH workforce shortages and provide needed services to our Members.

Streamlining Tracking of the Existing Direct Care Workforce

Proposed Statewide Direct Care Worker Tracking System

We are collaborating with Solvative, a digital solutions vendor in Overland Park, to develop an independent Statewide DCW enrollment and employment tool that can be used across the state by both Kansas Department for Aging and Disability Services (KDADS) and all Kansas MCOs and agency employers to meet new requirements for tracking DCWs. Since individual DCWs are not enrolled or assigned a State Medicaid ID and are not credentialed individuals, they are essentially "ghosts" within the system and have been, up to now, almost impossible to track.

Solvative, with UnitedHealthcare consultation and funding, is creating new technology to be a Statewide DCW enrollment database to be implemented in collaboration with the State, other MCOs and agency employers. This database will be managed independently by Solvative to

ensure conflict free use of this important resource. In this database, DCWs will input their required employment information and their required (and extensive) information for Provider qualifications.

How it works: When a DCW starts a profile and enters all their contact information, they will choose the services they want to provide and the waivers under which they prefer to work. The system will give them prompts based on input to compile the information and upload the documentation required to provide those services or work under the waivers they selected. The system will inform them which background checks are required and advise them that those background checks will be completed on their behalf.

Investing in Kansas

UnitedHealthcare is committed to investing in partnering with Solvative, a Kansas digital solutions vendor, to create a Statewide DCW enrollment and tracking system that will dramatically improve management of the DCW workforce and service capacity.

Multiple benefits: We recognize keeping DCW employee files current and in compliance with CMS regulations is very difficult with this workforce and has resulted in corrective action plans (CAPs) for the agency employers and the State. This database will track all requirements and send 90-day advance reminders to the appropriate parties when it is time to renew background checks, upload a new driver's license, or any other periodic requirement built into the database. When individual DCWs do not keep their employment profile current, they will be marked as ineligible to work under HCBS until their profile is current. This tool verifies only DCWs who are in compliance with regulations will be allowed to work, helping to mitigate the CAPs currently in effect.

We are excited to offer this new groundbreaking technology to the State for approval and further input. Once approved and implemented, to achieve maximum benefit, we will require all DCWs and all network Providers who have DCWs to use this tool, and we will promote adherence to other agencies and MCOs in the State. This tool will significantly improve the ability of organizations in the State to track the available DCW workforce, service capacity and gaps to maximize the effectiveness of DCWs across the state while also helping to resolve CAPs across the state — tracking components of the DCW workforce (e.g., employment files, Provider qualifications). This database will reduce administrative burden of the agencies and Financial Management Services (FMS) Providers who are required to conduct periodic audits of the DCW workforce because audited information will be available in one place and Providers are immediately notified on individual eligibility towork in the HCBS field.

Expand Training and Educational Opportunities for those Entering the HCBS Workforce

Community College and Tech School Program

Many Kansas community colleges or tech schools offer Home Health Aide or Certified Nursing Assistant programs. While these programs offer a foundation for those entering the HCBS workforce, programs require additional support to cover comprehensive training. Monitoring the HCBS workforce in Kansas, we know that many new workers in HCBS settings do not feel adequately prepared for the job. Because of the specialized nature of the jobs, DCWs need a specialized curriculum that adequately prepares this potential workforce for employment in this career and the settings in which they may work. We will work

Preparing an HCBS workforce

Approximately **37% of new HCBS workers** quit their jobs in the first week because they were inadequately prepared for the working conditions.

with current DCWs and agencies and collaborate with the State and other stakeholders to develop a specialized curriculum tailored to DCWs (see our section on *Long-Term HCBS Workforce Development Strategy*), we will continue to use the existing curriculums and have worked with Wichita State University to develop supplemental training modules for the HCBS workforce as indicated herein.

Immediate HCBS Workforce Development Strategies

Offer supplemental training: We have partnered with Wichita State University (WSU) to implement a supplemental training module for both potential and existing HCBS workers that teaches skills and strategies for task completion and addressing worksite challenges. DCWs can enroll in this training to expand their expertise or comfort level in addressing issues they may encounter. The WSU training module consists of three certificates that comprise eight badges:

Investing in Kansas HCBS training

UnitedHealthcare provided a grant of $100,000 to Wichita State University to support their work on training, recruitment and retention of DCWs.

- Basic Certificate (for completing Basic parts 1 and 2 badges)
- Initial Proficiency Certificate (for completing Initial Proficiency parts 1 and 2 badges)
- Advanced Proficiency Certificate (for completing Advanced Proficiency parts 1 – 4 badges)

In the pilot launch, there were 42 DCW apprentice candidates enrolled, representing 12 different counties in Kansas and one county from Missouri. Because coursework for each badge is online over a period of 15 weeks, none of the enrollees has yet completed the entire series.

Short-Term HCBS Workforce Development Strategy

Use existing resources: Because development and approval of a Statewide specialized curriculum for HCBS-bound workers will take time to draft, review, be approved and then be implemented by community colleges and tech schools, our short-term strategy is to continue to use the existing programs for home health aides (HHAs) and certified nursing assistants (CNAs). While they do not encompass everything a specialized HCBS curriculum will, they do provide a good foundation for those entering the HCBS workforce. We will then promote the current WSU badge and certificate training modules to HCBS Provider agencies and HCBS DCWs for supplemental training to better prepare this workforce.

In promoting the existing HHA and CNA programs, we will promote DCW as a job option to both high school and college-age students. For high school students, we will promote the fact there is no cost for them to begin this coursework in high school, and we will include the DCW program in marketing materials disseminated at high schools. We will promote awareness of the Kansas Promise Act Scholarship program for incoming and existing college students to complete their course of study with financial assistance. Finally, for college-age students, regardless of their course of study, we will promote DCW as a part-time job while they attend college, emphasizing they can work as much or as little as they want and set their work schedules.

Training Reimbursement for Existing DCWs: UnitedHealthcare will set aside up to $100,000 annually to allow agency and FMS Providers to compensate DCWs for time spent completing required or enrichment training, such as the WSU Badge and Certificate program.

Long-Term HCBS Workforce Development Strategy

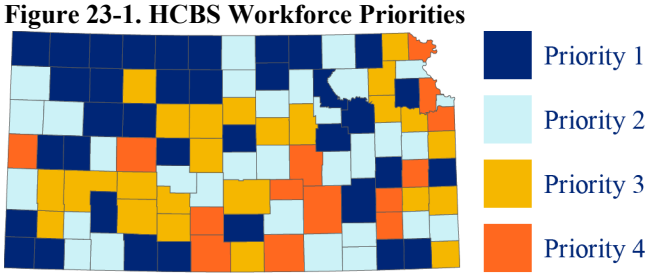
Specialized curriculum: We will collaborate with Kansas HCBS stakeholders, community college and trade schools, and the Kansas Board of Regents (KBOR) to develop and help fund a curriculum specifically tailored to DCWs (inclusive of DCWs, CNAs and HHAs) in an HCBS setting. As part of this collaboration, we will partner with HCBS Provider agencies to develop specific strategies to be incorporated into the curriculum to help address problematic issues related to burnout or turnover in the HCBS workforce. This curriculum would include intern or "shadowing" hours with a current DCW for real-life experience. We will partner with KBOR to roll out the planned DCW curriculum at the same time across the State so it will be widely available to help keep pace with the HCBS workforce shortages. This proposed curriculum will prepare graduates for the myriad of settings and circumstances they will encounter in their jobs, including diverse home settings, individual family dynamics around the HCBS Member and even safety issues. It will include strategies on mitigating challenges, defusing conflicting input from family members and making job safety a priority.

Opportunities to Guide Students into HCBS-Related Programs

As part of our workforce development efforts to guide students into HCBS-related programs, we will promote the Kansas Promise Act Scholarship. The Promise Act Scholarship requires completion of high school or a general equivalency diploma (GED) in the previous 12 months and can provide up to $20,000 for each student enrolled in health care coursework, a Kansas high priority career field. After completion of the coursework, recipients must live and work in Kansas for at least two consecutive years. Until implementation of the pending DCW coursework, recipients can still pursue the HHA or CNA coursework option.

Leveraging the Kansas Promise Act Scholarship: We will advocate to students graduating from high school and college-age young adults to apply to the State-funded Promise Act Scholarship program and share the benefits of working as a DCW, including the ability to set their schedule and working hours. The Promise Act Scholarship program offers up to $20,000 in financial aid per Kansas student over their lifetime. We will conduct outreach and marketing for this program to high school juniors, through Career Days at high schools and even Open Houses at the college level in which high school students are invited to tour the campus. In both venues, our care coordination staff will attend with current DCWs to promote the career choice at campuses across the state, speak to interested students and distribute promotional materials. We will focus our efforts in and around counties with the greatest need for DCWs or the highest percentages of unfilled HCBS service hours, as shown in the figure, in which we will prioritize efforts in Priority 1 counties, and Priority 4 counties reflect the counties with less need based on HCBS service hours filled.

Figure 23-1. HCBS Workforce Priorities



Strategies to Successfully Recruit those Graduating from Training and Educational Settings into the HCBS Workforce

Marketing and Recruitment Campaign

Our efforts in developing supplemental DCW education and training with WSU have been independent of the other MCOs in the State. However, because the shortage of HCBS workforce is a Statewide issue, we believe a collaborative effort is the most reasonable and best course of action for a marketing and recruitment program to eliminate duplication of effort and expense by individual MCOs. A unified marketing and recruitment effort will result in the most benefit to Members who are currently not receiving all the HCBS to which they are entitled.

Advisory Committee: The State has mandated the creation of an Advisory Committee in which all the MCOs and other stakeholders will participate to coordinate, plan and implement workforce development initiatives. In the past, we have supported the State in chairing quarterly FMS Committee meetings, and we have participated in meetings and workgroups with other MCOs and the Department of Education to collaboratively develop and promote a clear job path for the HCBS workforce. These collaborations have informed our immediate, short-term and long-term strategies to address HCBS workforce shortages.

- We would be happy to chair and run the Advisory Committee on behalf of the State or support the State in whatever role we can. If we are selected to chair the Advisory Committee, we will use the Advisory Committee to help direct the Statewide marketing and recruitment plan for DCW workforce, as part of the Advisory Committee scope of responsibilities.
- Otherwise, we will convene a workgroup with the other KanCare MCOs to form a unified marketing and recruitment effort to attract and recruit HCBS workers into the workforce, since HCBS Members Statewide will benefit from an influx of DCWs. We will contribute funding with the other MCOs (who are required to collaborate to help mitigate the DCW shortage) for shared recruitment staff to contact and direct DCWs toward the HCBS staffing agencies. We will hire a marketing firm to deploy both a standard marketing campaign and a social media campaign in tandem with the shared recruitment staff to achieve maximum saturation.

Workforce Development Manager: Pursuant to the **Scope of Services 13.5.9.G.8.**, UnitedHealthcare will hire a workforce development manager to lead our workforce development activities in Kansas. This workforce development manager will serve as the main point of contact in coordinating our activities related to both our workforce development commitments made in this response and in complying with other workforce development metrics delineated in **Scope of Services 13.5.9.G.9. and 13.5.9.G.10**.

Strategies to Successfully Retain Those Entering the HCBS Workforce

Careforth Partnership: In Kansas, we will partner with Careforth to deliver caregiver support services to nonagency caregivers, which includes both informal supports and paid family caregivers. Careforth is a state leader in the caregiver industry with solutions focusing on engaging, empowering, educating and supporting caregivers. Through Careforth, caregivers are assigned a coach who provides education on caregiving topics through an approved curriculum and is available to discuss caregiving concerns unique to the caregiver. The program's goals are

to increase active engagement in the Member's care team, increase caregiver confidence and reduce caregiver burnout.

CareBridge Support: CareBridge is an additional resource we will deploy in Kansas to support both Members and DCWs providing services to the Physically Disabled and Frail Elderly waiver populations. When a DCW encounters a problem they do not know how to address, they can contact CareBridge through a tablet provided to the Member by CareBridge and UnitedHealthcare. CareBridge staff can help de-escalate a difficult situation or provide other guidance designed to allow the Member to remain in their home. Kansas Members engaged in CareBridge programs experienced strong clinical outcomes, including a 10% decrease in skilled nursing facility admissions, an 11% decrease in hospital admissions and a 5% decrease in emergency department visits.

Mothers in Medicine Support: UnitedHealthcare will provide money via a grant to the Mothers in Medicine program to support mothers who work on the frontlines of health care by providing financial grants to help subsidize the cost of childcare. Anyone who works in a health care setting is eligible to apply to receive this childcare subsidy, enabling them to continue working. This support benefits workers in the shortage areas (e.g., DCW and Nurses) to obtain short-term childcare in case of unexpected financial crises or while awaiting their first paycheck.

Nursing Loan Repayment Program: We will focus on nursing staff (RN, BSN, LPN) retention and addressing the workforce shortage in Kansas. This proposal will offset the preference of most nurses who participate in the federal loan repayment program to choose to work in either hospitals or clinics, leaving a shortage of nurses in the HCBS field. We will implement a nursing loan repayment program for individuals graduating from a nursing curriculum. After a nurse completes one year of service in the HCBS field on either the Kansas Technology Assisted (TA) waiver or the Intellectual and Developmental Disability (IDD) waiver, UnitedHealthcare will pay $12,000 toward that nurse's student loan(s) to incentivize nurses to work in the HCBS field. The number of nurses who participate in this loan repayment program will depend on the level of need, location and number of eligible nurses wishing to participate, but we have an upward limit of 25 qualifying nurses in the program at any one time.

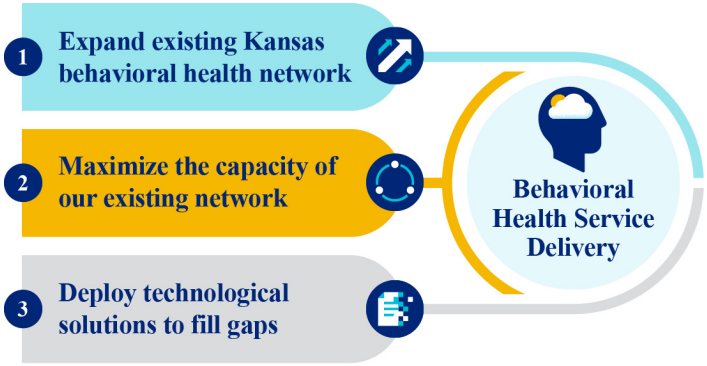
Recruiting HCBS Nurses

UnitedHealthcare will sponsor a Nursing Loan Repayment Program for nurses working as part of either the Kansas TA waiver or the IDD waiver.

Our Approach to Addressing Workforce Development Challenges for Behavioral Health Services in Kansas

Partnering as an MCO in Kansas since 2013, we understand the challenges associated with ensuring an adequate workforce to provide the BH services needed by our Members. Our approach to overcoming these challenges involves a three-pronged strategy, as shown in the figure and described herein.

Figure 23-2. Overcoming BH Workforce Challenges



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Workforce Development Investments

Increasing the Peer Support Workforce: We will support individuals with experience in BH and substance use disorder to become certified peer support specialists (CPSSs) as a workforce initiative that develops more capacity within the Kansas system. We will allocate funding to be used to cover costs of the training-related travel, lodging, meals or other appropriate expenses, which will vary by individual.

CPSS is a credential for individuals with personal experience in their recovery or experience as a family member or loved one and is a vital and proven component of our BH array. By offering insight into the recovery process based on their experience, CPSS can provide a unique perspective to those with similar life experiences. Peer support services are billable under Kansas Medicaid when a CPSS is supervised by a licensed professional. In addition to covering training-related funding indicate above, our Recovery & Resiliency State lead is a certified Level II trainer, who provides this training at no cost to the State.

Motivo: Through our partnership with Motivo, master's-level BH professionals can obtain the necessary clinical supervision and peer consultation they need to achieve full licensure and enter the workforce, helping increase the number of licensed clinicians who can deliver person-centered care to communities. Motivo has 1,200 supervisors with over 45,000 hours of supervision over many different specialties and competencies. One of Motivo's primary tenets is an awareness of disparities and inequities, working to reduce them by helping with supervision and test prep to enable diversity in the workforce. Of Motivo's supervisors, 37% are clinicians of color, 26% have a doctorate degree and 18% are members of the LGBTQ+ community. With only 59.1% of African American and 70.4% of Hispanic social workers in Kansas passing their licensure exam on the first try from 2011 to 2021, Motivo's supervision and assistance with test prep can help them pass on the first try and bring them into the workforce sooner. We will partner with Providers who employ professionals who require supervision to help them bridge the gap in completing the necessary hours to become fully licensed.

Diverse Scholars Initiative: This new initiative addresses the pressing need for more health care professionals in the workforce. The United Health Foundation supports this endeavor, bolstering the 21st century health workforce through the Diverse Scholars Initiative. In 2022, the United Health Foundation committed $100 million over 10 years to support 10,000 underrepresented, diverse clinical professionals to deepen our efforts in health workforce diversity. This initiative is open to Kansans engaged in a qualifying health care course of study. We will make fund materials available in our marketing package for high school and college students in a section highlighting the various financial assistance opportunities open to them. We partner with multiple national nonprofit organizations to offer scholarships to future clinicians seeking careers as doctors, nurses and other clinical professionals, including the American Indian College Fund, the Asian and Pacific Islander American Scholars, the Hispanic Association of Colleges and Universities, the National Black Nurses Association, the National Hispanic Health Foundation, National Medical Fellowships, the Thurgood Marshall College Fund and the United Negro College Fund.

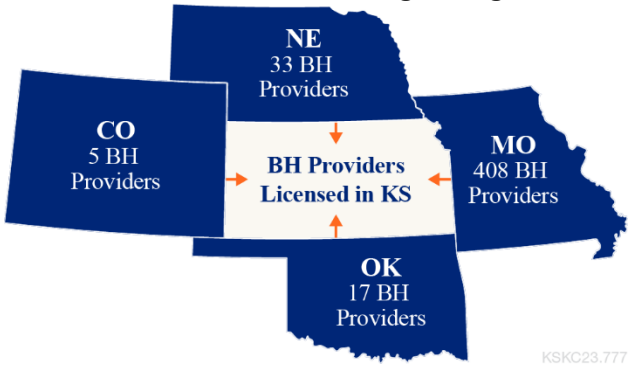
Expanding the Existing Kansas Behavioral Health Network

Contract with Qualified Providers: In Kansas, we contract with any qualified, quality focused BH Provider, especially those located in Provider shortage areas. UnitedHealthcare contracts

with any qualified BH Provider in Kansas, including all the Certified Community Behavioral Health Clinics (CCBHCs), all Community Mental Health Centers (CMHCs) and all Federally Qualified Health Centers providing BH services. We are committed to contracting with additional qualified facilities not currently under contract.

Expand Beyond State Lines: We understand there are Members who live near the Kansas borders for whom the closest qualified Provider may be in a neighboring state. We are contracted with **127 Provider groups representing 463 individual Providers in Oklahoma, Missouri, Nebraska and Colorado** who are appropriately licensed and accredited (with Kansas Medicaid IDs) to provide BH care services to Kansas Members. We will continue this ongoing effort to expand the BH workforce, especially with regard to Kansas' shortage of prescribing Providers qualified to prescribe medications for pediatric mental health and medication-assisted treatment (MAT) for substance use disorders, specifically alcohol-use disorder (AUD).

Figure 23-3. UnitedHealthcare's Kansas-Licensed Behavioral Health Providers in Neighboring States



Expanding Use of Telehealth: We have been working diligently to add Providers to our telehealth network to supplement the local Provider networks. Our efforts have yielded a sustained **52% growth year over year** in Kansas, with **740 unique BH telehealth Providers** as of October 2023, and that number keeps growing. Telehealth is an excellent medium for BH services, comprising 79% of all telehealth claims in Kansas, including areas of focus such as remotely interacting with Members with a history of medication nonadherence. A clinician can engage a Member at a scheduled time every day and observe the Member taking their medication, contributing to medication adherence and stability.

Our telehealth network in Kansas improves access to health care and decreases no-show rates, helping Members consistently receive the services they need. This support is especially effective for Members with BH needs which might prevent them from leaving their homes, allowing them to receive services in the safety of their home environment. Our knowledgeable team of care coordinators and health care workers collaborate with Providers to confirm the adequacy and appropriateness of services. Telehealth services are provided across Kansas, including a wide range of BH services such as BH assessments, medication management and counseling. Our commitment to telehealth is unwavering as we continue to contract with high-quality Providers and invest in increasing telemedicine in rural and frontier areas such as investing in internet connections and telemedicine equipment.

Augmenting the Local Network: We recognize an opportunity to expand Provider access and network in both MAT and pediatrics, especially in rural areas. To address Provider shortages in these areas, we are contracting with other qualified Provider groups to fill in gaps. These groups will be appropriately licensed, have Kansas Medicaid ID numbers and will provide services billable under Kansas Medicaid, meeting Members either in person or virtually. Mindful of the existing Provider shortages in certain areas, we have carefully selected three national Provider groups to supplement needed services in Kansas: Affect Therapeutics, Backpack Healthcare and

AbleTo Virtual Therapy, as described in the following table. All these Providers are new to Kansas and will roll out in 2024.

Providers	Program Description	Benefits
AbleTo Virtual Therapy	AbleTo provides virtual therapy programs with licensed therapists, leveraging the principles of cognitive behavioral therapy for people with mental health needs. Their program includes pathways for Members who are postpartum or have comorbid chronic medical conditions, such as diabetes, hypertension and chronic pain.	AbleTo is committed to timely access, with an average of six days to initial appointment. Further, 48% of high-risk patients who engage in the program have experienced a reduction in hospital admissions.
Affect Therapeutics	Affect Therapeutics' evidence-based digital treatment program for alcohol and stimulant use disorders offers effective, intensive treatment to people with access to care issues or those who prefer not to visit inpatient or outpatient clinics. The program is convenient, discreet and affordable, breaking down barriers to effective treatment and offers financial rewards to improve engagement. Members have access to counselors, coaches and medical Providers for MAT for AUD.	Affect is a proven vendor we have used in 10 states with positive results. In Nevada, 57% of our Members engaged in treatment (vs. 14% national benchmark), and 79% initiated treatment within 14 days of diagnosis.
BackPack Healthcare	BackPack Healthcare provides personalized, accessible and inclusive pediatric mental health care to our Members through a self-care app, pediatric and family therapy and family training. Sixty-five percent of BackPack Healthcare staff are BIPOC.	Users report less than a five-day turnaround from referral to first appointment, and greater than 60% of patients complete more than 10 sessions.

Maximizing the Capacity of Our Existing Network

Reducing Provider Administrative Burden to Enhance Capacity

We recognize as administrative burden goes down, time for patients and Provider morale go up. One effective approach is streamlining the clinical review process for prior authorizations, which we have successfully implemented in several states. Moreover, we are investing in new technology that directly integrates our applications into our network Providers' electronic medical record (EMR) systems, creating a centralized data repository to push and pull critical clinical information into and out of EMRs. Lastly, we incorporate strategies such as e-prescribing, which enables physicians to send prescriptions electronically directly to a pharmacy. This modernization decreases costs by reducing errors and improving efficiency and compliance. In network discussions, we actively seek input on opportunities for administrative simplification,

"As a new Provider and small business, trying to learn and retain all the new information can be very frustrating and confusing. However, **the Provider training has proven to be beneficial** in clarifying some of the primary, as well as small, details regarding the administrative and daily processes required to efficiently get my job done. For example, the step-by-step instructions provided regarding various claim submission issues. **I still have SO much to learn and I'm grateful for the supportive and effective training/resources provided thus far. I truly appreciate this assistance.** Thanks again!"

– Anita Gee

Halo Behavioral Health and Day Center

particularly for Providers with value-based purchasing agreements. Overall, reducing Provider administrative burden entails a combination of education, simplification, technological integration and continuous collaboration, leading to a more efficient and seamless health care provision. We have the expertise and experience to maximize these efforts on behalf of Kansas Providers and free up additional capacity within our current Provider network.

In 2023, BH staff conducted a "listening tour" with six CCBHCs in the State to hear, directly from the frontline BH Providers, what is working and what improvements are needed in the system. Feedback included a desire to collaborate on sharing Member data to help the CCBHCs reach their more acute Members in the community, real-time notification of emergency department (ED) discharges of their Members and support for data analysis around performance of the CCBHCs. This feedback was shared with leadership to inform continued work to increase support for Providers in the network. As a result, the value creation team has created reports and training to enable CCBHCs to view trends and performance reporting. We will leverage these reports in ongoing collaboration with CCBHCs.

STAR Utilization Management: Smart Technology Authorization Review (STAR) utilization management (UM) system is a technology-driven process for the review of medical necessity and clinical appropriateness of an authorization request (initial and concurrent reviews) when necessary for inpatient, residential, partial hospitalization program and intensive outpatient program levels of care. If an authorization request does not meet expected cohort norms, we solicit additional information from the Provider through our STAR UM portal. Response through the STAR UM portal reduces the clinical review to less than 10 minutes, whereas a follow-up telephonic review of the request takes an average of 32 minutes. This portal saves an average of 22 minutes in Provider time per authorization review. **As of November 2023, we reviewed 1,375 authorization requests through the STAR UM portal, saving over 500 hours of Kansas Providers' time.**

"Working in the accounting department of several medical Providers for the past three years, I have had my fair share of interactions and correspondence with insurance companies. I can say, without a doubt, that UnitedHealthcare is easily the **most user-friendly portal** that there is when it comes to the three MCOs that Kansas provides. **Being able to research, reconsider, appeal, correct all on the portal as well as being able to search authorizations (with minimal hassle) makes my job of balancing the accounts and working denials super efficient**. I know that when I call the UnitedHealthcare representatives to inquire about claims, auths, eligibility or anything else, **I can expect friendly and concise conversation and end the call knowing that my concern has been addressed and any action that can be taken on UnitedHealthcare's end, will be taken."**

– Angel Toral, Inspire ABA

Platinum Recognition: This program is a quality-based recognition program active in Kansas and specifically helps remove administrative burden to Providers by providing an abbreviated review process for the patients admitted to a recognized program. The Platinum program identifies and rewards facilities for delivering services more effectively and efficiently. By using data analytics, we identify the top performing facility programs in each region, by condition category and level of care. We are actively promoting the program, and there are currently five Platinum BH Providers in Kansas.

Expanding Provider Capacity through Training Support

We are investing to help Providers acquire the training they need to expand their scope of practice and treat Members with a larger variety of BH issues, as indicated herein.

Psych Hub: We have invested to make 200 Provider Psych Hub licenses with training available to Kansas Providers for free in early 2024. Psych Hub will offer trainings on the following topics, helping to address current Kansas priorities:

- **Optum Suicide Prevention Series** (*psychhub.com*): These programs enhance health care Providers' knowledge and skills, and facilitate more empathetic, understanding and trauma-informed care (TIC) to promote healing and reduce the risk of retraumatization. The training incorporates principles of TIC, emphasizing the importance of expressing understanding and empathy in interactions with individuals.
- **Optum Adolescent Treatment Series** (*psychhub.com*): This specialized program equips health care Providers with knowledge and skills necessary to address the unique health needs of adolescents. The goal is to make sure all adolescents, regardless of their background or circumstances, receive quality, equitable care to promote healing and reduce retraumatization. The training incorporates elements of the Early and Periodic Screening, Diagnostic and Treatment approach, Care Philosophy Training, TIC and Adverse Childhood Experiences.

Skills System: This voluntary two-day training for clinicians and agencies supports competencies development in the IDD treatment modality, such as Providers who are comfortable treating BH needs but may lack the skills to treat individuals with co-occurring IDD and BH needs. Skills System implementation provides accessible, tangible emotion regulation strategies to both individuals with IDD and the members of their support systems, such as family caregivers and paid staff. Individuals in treatment and those who support them learn skills so they can (a) use skills themselves or (b) be in-vivo skills coaches within the individual's life. Skills System tools are designed to help all involved (clients, staff and family members) improve their self-regulation and co-regulation capacities. Leveraging this training geared toward the IDD population, clinicians can expand their scope and serve this at-risk population. We will offer this training for up to eight interested agencies in Kansas, which includes a year of group E-learning memberships for up to 40 staff per agency.

Additional Training Opportunities for Existing Providers

We will make additional training programs available to Providers to expand their scope of practice or achieve free continuing education units (CEUs) for existing licensure, from hundreds of educational opportunities on one easy-to-navigate location, and **free to Providers.**

Optum Health Education™ (OHE) Trainings: We will continue to offer OHE to Providers support training Providers need for current or additional certifications or licensure and scope of practice expansion to treat a wider variety of BH conditions. OHE offers accredited, on-demand free CMEs or CEUs to licensed clinicians, covering a wide variety of topics. Over the last two years, Kansas Providers have earned over 3,400 CEUs through OHE. The **total benefit to Kansas Providers since Jan. 1, 2021, includes 2,652 courses taken, with 3,432.75 credits earned (through Aug. 23, 2023).**

Supporting Kansas Providers via Optum Health Education (OHE)

Over the last few years, Kansas Providers have earned over 3,400 CEUs through OHE:

- 2021: 801 courses taken and 1,006 credits earned
- 2022: 904 courses taken and 1,239 credits earned
- 2023: 947 courses taken and 1,187 credits earned

Deploying Technological Solutions to Fill Gaps

There are value-added solutions available to deliver an array of BH services to reduce the burden on the network and provide the Member control over their health. These initiatives are available to support Members aged 13 and older and can assist with coping skill development, reduction of stress and increased resiliency. The following are some benefits available to KanCare Members through non-billable services:

Solution	Program Description
Pyx Health (Live in Kansas)	Pyx Health uses a Pyxir chat box or live agent to support Members with social isolation, assess their risk of loneliness, use companionship and humor, and provide resources to boost physical and mental health while making the most of their health plan benefits. Pyx connects Members with resources and provides routine follow-up. Those identified to have an urgent need are referred to a Community Health Worker with whole person care. Between December 2022 and September 2023, 1,394 Members were onboarded, 47% scored lonely, 66% identified SDOH needs and 10% were high acuity. Pyx Health is live in Kansas.
Self Care (Live in Kansas)	Self Care by AbleTo is an anytime, anywhere, self-paced digital program offering evidence-based mental health support, including assessments, trackers, mental health skills and tools, collections and communities. It is intended for Members with low severity or complexity BH conditions and enables resilience by building new skills and daily habits. Self Care is currently live in Kansas under the Sanvello name.
Supportiv (Jan 2024 go-live)	Supportiv provides on-demand peer-to-peer mental, emotional and social support in small group chats available 24 hours a day, seven days a week, to **high school age teens** who do not receive other mental health care. All group chats are supervised by trained (human) moderators. Services are **HIPAA compliant and** offered on an anonymous basis with no IDs or profiles and are accessible on any device. Supportiv will roll out in Kansas in January 2024.

As we continue to implement innovative solutions helping Members with BH conditions, we look forward to continuing our partnership with the State in formulating meaningful solutions andin developing new strategies to provide essential services to the Members.

Provider Network

24. Describe the bidder's identification of network gaps in dental Providers in KanCare and the bidder's approach to ensuring KanCare Members have timely access to quality dental care in Urban, Rural, and frontier areas. Include example(s) of the bidder's successful use of a comparable approach in program(s) similar to KanCare, the measurable impact achieved, and how the bidder will apply this experience to benefit KanCare.

Since the beginning of the KanCare program, UnitedHealthcare has remained dedicated to the oral health of Kansans through greater access and quality. Our dedication to oral health has been a contributing factor to our position as the MCO of choice for Members. In 2013, we were the first MCO to offer KanCare adult Members dental cleanings and exams as a value-added benefit. Understanding the needs of our Members and the importance of dental care, we expanded our value-added benefits for adults in 2019 to include restorative coverage, such as fillings, up to a $500 value. In July 2023, the State expanded adult dental benefits to include some restorative and denture coverage. We continue to offer cleanings, X-rays and now allow the $500 value-added benefit to include necessary root canals.

From 2013 to present, we continue to improve dental care for our Members through a multifaceted approach, which includes:

- Identifying network gaps and recruiting Providers to close gaps
- Ensuring Members have timely access to quality dental care in urban, rural and frontier areas
- Continuous improvement for oral health in Kansas
- Applying our experience to benefit KanCare Members

In 2022, we had an adequate network based on Member access standards, and we continued to advance our ongoing improvement efforts. We made an administration change and brought our dental network contracting and management in-house with Dental Benefit Providers, Inc. (DBP), a wholly owned subsidiary of UnitedHealth Group Incorporated. Our oversight of service level agreements and monitoring of DBP has consistently demonstrated an integrated focus on care and alignment with Providers to promote improved coordination and access to care, which leads to better Member outcomes. In addition, their commitment to tailoring systems of care demonstrates flexibility and dedication to personalized care. As part of our constant improvement efforts, we made this change to improve the dental plan experience for Providers and Members. Our focus on improving the Member experience and satisfaction has been recognized as we are currently the highest-rated NCQA health plan.

2023 Provider Feedback

"Partnering with UnitedHealthcare over the last year has been markedly improved since UnitedHealthcare took over the contract. Prior to the new contract management, we had numerous on-going issues with claims being processed incorrectly and problems with customer service understanding and implementing UnitedHealthcare's own claim requirements correctly."
– Lori Johnson
Fales Pediatric Dentistry

"Everything has been a much smoother process working with UnitedHealthcare since the transition to in house oversight. Having an accessible provider representative has made a tremendous difference."
– Barbara Vailas
Oral and Maxillofacial Surgery Associates

KSKC23.919

Identifying Network Gaps in Kansas

Today, 99.9% of our Members can access a general dentist within KanCare access standards. Our dental network continually meets or exceeds KanCare network adequacy requirements; however, we acknowledge there are gaps in a few counties due to lack of specialists available across the state. We are continually working to verify all Members have access to the full range of covered services and choice of dentists. We monitor the network for gaps by using Geographic Mapping Reports (Geo-Access), which demonstrate the strength of our network based on State access requirements. If there is a lack of general dentists or specialists in our dental network in certain counties, we will first coordinate care with a participating general dentist or specialist in a contiguous county for a Member. If that is not an option, we will negotiate a single case agreement with the closest out-of-network general dentist or specialist available. Our provider advocates analyze each county in Kansas and document each dental specialty Provider type available. We target for recruitment or negotiate a single case agreement if required to coordinate a specialty dental care needs for a Member.

Coordinating Dental Care

In 2023, we did not negotiate any single case agreements. We coordinated specialty care for two Members with Associates in Family Dentistry in Sedgwick County, a contracted general dentist that performs endodontic and oral surgery procedures.

When closing network gaps, our recruitment effort includes direct mail, personal phone calls to potential dentists and in-person recruiting. We target all Kansas Medicaid Providers, including those in the State directory, Medicaid competitor networks, our employer-sponsored and Medicare Advantage Providers, and all Providers in the state who may or may not participate in Medicaid or other employer-sponsored or Medicare Advantage plans.

Our provider advocates build and maintain positive working relationships with network Providers to support network retention, making quarterly outreach calls to every network Provider. For example, we partnered with Adventure Dental in Kansas City, providing food and beverages at an outreach event. At the event, we promoted the importance of oral hygiene and introduced Members to the dentists and team at Adventure Dental.

Figure 24-1. Adventure Dental Outreach Event

Ensuring Members Have Timely Access to Quality Dental Care in Urban, Rural and Frontier Areas

In the last year, we achieved 5% growth rate in dental Providers, which has created 169 access points, including 110 in urban areas and 59 in rural and frontier communities. We tailor our approach to network development in urban, rural and frontier areas. Our approach has evolved during our decade of experience in Kansas. For example, rural and frontier areas struggle with a shortage of dental professionals whereas urban areas have an adequate supply of

dental professionals but have a hesitancy to contract with Medicaid as opposed to employer-sponsored and Medicare plans. Our approach is guided by the following:

- **"Following the Member":** Using data analytics we use Member utilization reports and our experience within employer-sponsored and Medicare plans to identify Providers to recruit.
- **Understanding KanCare Dental Providers:** We are partnering with Oral Health Kansas to better understand participation barriers. This partnership will support development of solutions to increase access across the state.
- **Building Relationships with Providers:** Provider engagement is instrumental to our success. In December 2022, we brought our provider services in-house and increased our number of provider advocates to increase our support in rural and frontier areas.

Following the Member

In October 2022, we began a new network approach we call "Following the Member" to increase network growth and meet our Members' needs. We used data-driven analytics to identify and analyze Member utilization patterns, determine Members' preferred dentists, build relationships with dentists and solve for gaps in service. Based on a successful pilot, our network development strategy leverages learnings and guides us toward a more accessible, qualified and equitable dental network across the state.

Understanding KanCare Dental Providers

In 2023, we developed a Dentalcare Workforce Committee (DWC) with Oral Health Kansas. This committee is focused on obtaining and acting on purposeful feedback from KanCare dental Providers and administrative staff across the state to remove barriers and improve access in urban, rural and frontier areas. While UnitedHealthcare is a thought leader and collaborator supporting the KanCare dental health care system, Oral Health Kansas has proven to be a productive partner that works closely with us to advance the conversation of dentists who will become Medicaid Providers. **We are making a $10,000 community investment to Oral Health Kansas to distribute a survey to Providers, as well as a stipend to participate in the committee, to better understand the barriers for dental Providers to participate in serving Medicaid Members.** We will use this insight to drive recruitment and continued partnership.

Building Relationships with Providers

One approach to enhancing our dental network in urban, rural and frontier areas is building relationships with Providers. While we regularly outreach to potential Providers, we work to maintain relationships with our existing Providers to help them serve KanCare Members. We actively listen to Providers' concerns and address their needs. For example, we recently worked with the federally qualified health center (FQHC) Genesis to address their claims concerns. During virtual meetings, a claim subject matter expert (SME) and several Genesis staff members worked together to address specific claims questions. The claim SME walked Genesis through the process of submitting corrected claims electronically, connecting a Provider's ID to the facility and understanding the explanation of benefits. Follow-up with Genesis was conducted after the meeting to answer any new or outstanding questions. Claims have been submitted correctly since the virtual meetings. We use these connections and learnings to enhance the Provider and Member experience.

Addressing Providers' Concerns

We recently connected with Dr. Hargreaves, who serves in an urban area where younger dentists are not accepting Medicaid Members. He was unhappy with the limited coverage and Medicaid reimbursement. Our director of operations met with Dr. Hargreaves and listened to his concerns. Together, they reached a resolution, so Dr. Hargreaves continues to see his membership and receives maximum reimbursement for services rendered. Dr. Hargreaves remains in-network, and we continue to recruit other dentists in his demographic area.

Monitoring Network Adequacy

We monitor our network adequacy through Geographic Mapping Reports (Geo-Access) to confirm we are meeting State access requirements. We track Member grievances and appeals to monitor access to care grievances, which our provider advocate will address with specific Provider offices if we detect an issue for Members obtaining timely access to care based on Provider contract requirements. In addition, we conduct appointment access and waiting time surveys. We require network dentists and specialists to schedule routine or preventive dental services no later than six weeks from request of service. Members in need of emergency care must be seen within 24 hours.

Dental Network Strength

General Dentistry

645 Access Points

233 Locations

Specialist Dentistry

223 Access Points

79 Locations

KSKC23.646

Recruitment of Dental Providers

Our goal is to build positive working relationships across our dental network to support Providers so they can focus on delivering excellent Member experiences from start to finish, which is what matters most. As the range of covered dental services has increased, we have been successful in recruiting additional Providers to serve our Members. Our recruitment process entails the following strategies:

- Map Member enrollment and dentist population by ZIP code to determine the network access of general dentists and specialists in each county across the state via Geographic Mapping Reports (Geo-Access).
- Target Medicaid Providers on the State Medicaid list, the Medicaid competitor directories and our existing directly contracted employer-sponsored and Medicare Advantage PPO Providers who do not currently accept Medicaid.
- Use direct mail, telemarketing and in-person recruiting. We recruit general dentists and specialists who deliver quality care in an appropriate setting and agree to participate in cost-effective treatment protocols.
- To support network access and compliance, we will negotiate higher fee schedules with Providers in certain rural and frontier areas to support network adequacy and incentivize Providers to serve those areas.
- We engage recruited Providers in the credentialing and State licensing process for primary source verification for approval as a contracted Provider before Providers can provide contracted services to Members.

In December 2023, we launched a recruitment campaign across 34 rural Kansas counties, targeting 24 Providers on the state Medicaid list and 60 additional Providers who do not

currently accept Medicaid for addition to our network. Providers include all dental specialty types: general dentists, pedodontists, endodontists, oral surgeons, periodontists and orthodontists.

Continuous Improvement for Oral Health in Kansas

As a trusted partner, we are committed to continually improving the KanCare dental program. Our Kansas-based team will continue to build and maintain our dental network through partnerships with Provider associations and network Providers, especially those treating a high-volume of our Kansas Medicaid Members, such as ICTeeth Pediatric Dentistry, Twin Lakes Dental PA, Community Health Center of Southeast Kansas, Adventure Dental, Heartland Community Health Center, LeBlanc and Associates Dentistry for Children, Gracemed Health Clinic and many others that we partner with in dental care delivery.

Making a Member Smile

"Right now at this present time I don't think they can make it any better than it is, for me it's perfect. I got to see a dentist for nothing. Everything connected to my health UnitedHealthcare is doing very well."

– Member Testimonial

We have **three dedicated Kansas-based provider advocates** who serve as direct points of contact for dental Providers. They help Providers identify and resolve issues, conduct initial program and refresher training, offer program support, problem solve to avoid escalations and perform spot network recruitment to expand our dental network to close access gaps when necessary. Our provider advocates reside in Kansas and are geographically located to manage the most populated Medicaid counties and outlying rural areas. Our provider advocates have cultivated strong and productive partnerships with all Medicaid Providers and their staff through consistent communication and education. Our provider advocates prioritize maintaining open lines of communication with Providers to support a strong and collaborative partnership. To achieve this, provider advocates are committed to proactively reaching out to every contracted Provider group at least quarterly. This regular contact helps us stay informed about any significant changes in Providers' needs or goals, enabling us to provide the best possible support and value. We conduct monthly reviews of the State Provider file to identify any updates or changes to Providers' enrollment. In addition, provider advocates are readily available to receive phone calls and emails from Provider offices to assist with their concerns, questions and escalations.

Continuous Improvement

In December 2022, UnitedHealthcare completed a Provider migration that resulted in improved accuracy in our Provider counts. With an increased focus on the Provider network and our relationships with Providers, UnitedHealthcare brought provider services in-house. As part of this change, we increased the number of provider advocates from one provider advocate to three provider advocates. The increased provider advocates helped expand our capabilities to educate Providers and work one on one with Providers to close dental gaps and expand access to dental care. As of December 2022, we had a total of 703 access points. In 2023, we added 176 access points of which 169 access points were in urban, rural and frontier counties in Kansas. As of November 2023, we achieved a 5% growth rate.

We are committed to in-office visits and Dental Advisory Committee (DAC) sessions to both educate and gather feedback on our service and Provider resources. The DAC meetings with Providers allow us to gather direct feedback on our KanCare program administration, network management, utilization management, Provider services support, claims processing and other initiatives to

improve and enhance how we support Providers and serve Members. Earlier in 2023, we used our DAC meetings to communicate existing and new Provider resources to help streamline Provider administration. We introduced the My Dental Care Passport capability on our provider portal as a Provider resource for our IDD and special needs Members. My Dental Care Passport gives Members and their families or caregivers an opportunity to voice their specific needs before arriving at the dental office to decrease the need for sedation dentistry. In addition, we support Providers and dental organizations by participating in conferences and community service, such as Oral Health Kansas, the Midwest Dental Conference and Kansas Mission of Mercy.

Applying Our Experience to Benefit KanCare Members

Dental benefits for KanCare Members changed significantly in 2023, creating a greater incentive for Members to receive education regarding the importance of oral health and proactively use their benefits.

Expanding Dental Care Benefits

Adult health dental benefits have expanded over the past two years. UnitedHealthcare was the first KanCare MCO with value-added benefits to provide dentures and progressed adult dental to include preventive and restorative dental care for the physical disability waiver population. We implemented a process for medical necessity review and we provided sedation dentistry, for medically necessary cases, through the in-lieu-of process since KanCare 1.0.

Sedation Dentistry

Access to Sedation dentistry continues to be a barrier to care. We joined the Sedation Dental Care Task Force in 2022 as a founding member. To help improve access for sedation dentistry, we began offering enhanced rates for sedation dentists. In addition, we have been working with Oral Health Kansas on the development and distribution of the My Dental Care Passport.

We recently conducted an outreach campaign to our entire network and have documented which Providers have sedation capabilities, the type of sedation, whether the sedation is performed in their office or off-site with a sedation third-party Provider, ages of the Members they treat and whether they treat Members with special needs. Most of our dental network coordinates sedation dental with Advanced Specialty Anesthesia (ASA), Special Anesthesia Services (SAS) and other third-party anesthesia Providers.

Figure 24-2. My Dental Care Passport

In our continued efforts to improve our network and understand Providers' capabilities, we contacted all Providers to inquire about their

sedation capabilities. Our outreach identified which Providers completed their sedation services, which Providers contracted with ASA, SAS and others and what specific levels of sedation they provided. This detailed information allows us to direct Members in need of sedation dentistry to an appropriate Provider. Members can contact member services for assistance locating a sedation dentist. In addition, we will be adding an identifier in the *Provider Directory* in 2025 to indicate which dentists offer sedation, and the level of sedation offered.

Addressing Barriers to Dental Care through Collaboration

"The Sedation Dental Care Task Force formed in the fall of 2022, and UnitedHealthcare has been at the table since the beginning. This task force is designed to learn about the barriers people with IDD face in accessing sedation dental care from the perspectives of the individual, caregiver, dental office, safety net clinic, and insurance company. The task force is preparing to deploy a survey of all dental offices enrolled in Medicaid regarding their capacity to provide sedation care. United will help administer the survey with their provider network. The goal of the survey is to compile a realistic list of sedation dental care referral sources in the state. We are especially excited about this survey because it will help address one of the goals in the KanCare RFP of managed care organizations tracking a list of sedation dental providers."

– Tanya Dorf Brunner, Oral Health Kansas

Examples of Successful Use of Comparable Programs

Provider Network

25. Describe the bidder's strategies and approaches to encouraging Provider network participation and improving the experience of Providers participating in KanCare.

We are passionate and persistent in improving the network experience for both Providers and Members. We constantly pair data, experiences and feedback to deliver demonstrated innovations that truly affect Members' lives and advance health equity. UnitedHealthcare will continue to be a trusted partner to help achieve the State goals of expanding the reach of the Kansas Provider network and direct care workforce while building capacity and skill sets. Our capability to comply with **Scope of Services 7.5.2** is grounded in our core capabilities of creating meaningful and lasting relationships with Providers, supporting Providers and bringing solutions to ease administrative burden. We listen and learn from Providers and Members in the community to identify network challenges and collaborate to remove barriers to care. Our approach includes:

- Encouraging Provider participation through identifying, recruiting and building relationships with Providers
- Improving the Provider experience by easing the administrative burden through people, training and tools

Over the last decade, we have grown roots in Kansas and formed a firm foundation of dependable health care and community presence, and we are ready to continue improving network Provider participation and the KanCare Provider experience. We are on the ground meeting Providers in person at conferences, association meetings, site visits or via telephone call or email. We are committed to supporting Providers to advance access to equitable programs, services and care for all Kansans.

Strategies and Approaches to Encourage Provider Network Participation

Since 2013, we have developed and fostered strong relationships with Providers, so that we know them and they know us. We are grounded in Kansas communities. We connect with Providers at association events and Provider conferences to build relationships and gain purposeful feedback.

Figure 25-1. Provider Services Leadership Attending Provider Conference

Identifying and Recruiting Providers

We use multiple strategies to encourage Provider network participation. We go beyond traditional recruitment methods and follow the Membres to Providers. After conducting thorough research and developing a Provider profile, our local network management and contracting director contacts potential Providers with a phone call. Providers are personally invited and welcomed into the network with step-by-step guidance throughout the entire process, including KMAP enrollment, credentialing and contracting. Early in the process, the local network team introduces new Providers to their assigned provider advocate.

Building Relationships with Providers

Whether it is an invitation to join the network, or a provider advocate reaching out for training, we listen and learn from Providers and interact with them frequently. Provider advocates meet with Providers in person at least twice per year, and more frequently, if requested. Provider advocates encourage network participation through personalized support and training with new Providers. Provider advocates help new Providers learn how to navigate UnitedHealthcare by sharing resources and tools, including the Provider Manual, our secure Provider portal *UHCprovider.com* and virtual trainings available online 24 hours a day, seven days a week.

Figure 25-2. Provider Services Operations Staff at Provider Conference

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Increased Provider Payment and Incentives

We work locally with Providers to develop individualized contracts and fee schedules to meet their practice needs. The provider relations director in Kansas has the ability to negotiate and approve contracts with Providers to meet the Provider's needs, even when providers need customized solutions. Our local network team has extensive knowledge of the State and the needs of the Providers, so we can develop custom VBPs that are simple for Providers to execute and benefit both the Provider and Members with the shared goals.

We support each Provider's path to success in value-based purchasing (VBP) through early and ongoing engagement, tailoring interventions to a practice's capabilities, resources, readiness and management style. We craft Provider-specific VBP incentives for Providers to be mutually beneficial to the Provider and our goal of increasing access and improving quality of care. Recently, we implemented three VBPs for pediatric practices in Manhattan, Wichita and Topeka. We selected these practices due to their focus on emergency department (ED) diversion for children, and their "after-hours clinics." We are also developing an ED diversion incentive for each of the Providers.

In recruiting new Providers, one common touchpoint for discussion is the Kansas Medicaid fee schedule, which is often lower than surrounding states' Medicaid fee schedules. our local provider relations director and other local staff are empowered to work with potential Providers to develop a quality-based fee schedule and VBP to meet the needs of Members and Providers.

Improving the Experience of Providers Participating in KanCare

UnitedHealthcare actively engages with Providers to improve Provider experience through collaborative solutions, removing barriers to care and supporting the delivery of effective, person-centered care. We engage through consistent conversations, in person or virtual meetings, and interactions at community events, association meetings and conferences, such as described herein.

Provider Engagement

Most Knowledgeable Team

"UnitedHealthcare has the most knowledgeable team. They are the first to understand issues, work with the state, and address them in a timely manner."

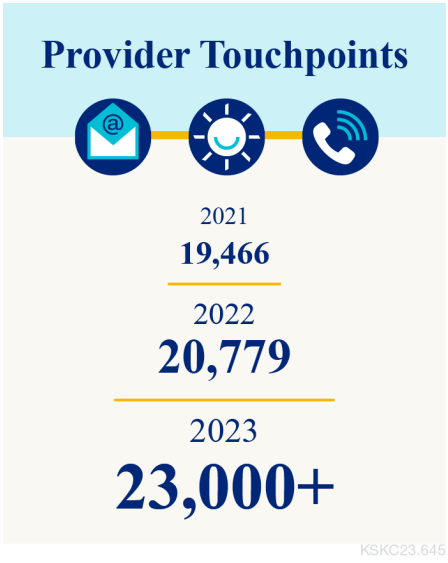
– Lynda Farwell

Stormont Vail Health System

The provider services leadership team attends multiple Provider conferences each year to obtain purposeful and actionable feedback from Providers. We use these opportunities to demonstrate leadership's commitment to supporting Providers, supporting our communities and listening to Providers. The provider services leadership team attended 24 conferences and spoke with nearly 6,000 Providers in 2023. Recently, we redesigned the Provider survey with the help of other KanCare MCOs through a third-party vendor using State-required methodology. The new survey has yielded improved participation, which gives us another way to obtain and act on Provider feedback. In addition, Providers participate in the Provider Advisory Council and CEO Forum to share their feedback on the KanCare plan.

Locally Based, Fully Dedicated Provider Advocate Team

Our team of Kansas-based provider advocates are dedicated to KanCare Medicaid. We introduce the assigned provider advocate to the Provider with their direct phone number and email during initial recruitment to support a successful onboarding experience. Our provider advocates are locally based and empowered to assist Providers in person or via virtual meetings, phone or email. Our provider advocates understand KanCare and the specific challenges Providers encounter. Our local presence allows our provider advocate to connect with Providers along with the knowledge and skill to quickly resolve Providers' questions. Provider advocates schedule meetings with Providers based on Provider preference — any frequency from every six months to weekly.



Provider advocates connect via email, in person and phone to help Providers with their KanCare experience and share information. Provider advocates help Providers with billing, the Provider portal, navigating the KMAP Portal and the Healthcare Common Procedure Coding System (HCPCS) lookup tool to determine State coverage. In addition, provider advocates help resolve claim issues and educate Providers on our overpayment and recovery process, including a review of top denials weekly, both by Provider and by type of denial code. The team addresses and educates Providers with a high volume of denials overall or those who are top contributors to the top denials by volume overall. We meet with Providers to review the denials, provide education on how to correct denials and teach Providers how to bill claims to avoid denials.

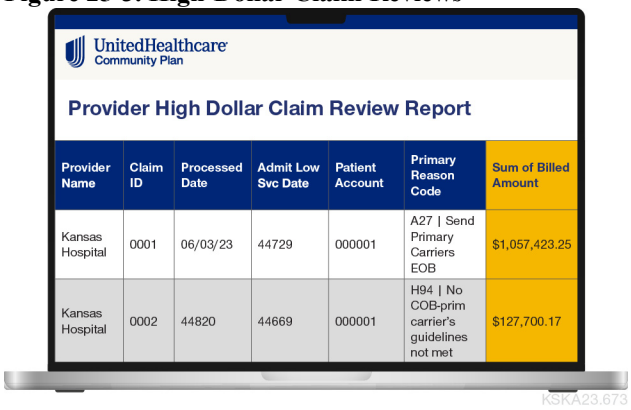
KanCare Provider Services Operation

Our dedicated provider operations team confirms State policies are implemented on time and accurately. The team produces weekly claims reporting for each Provider type for proactive reviews and outreach to Providers for claims denial. In addition, this team conducts a full root

cause analysis for all claim processing issues to validate long-term solutions. The provider services team tracks all issues discovered in reviews and audits to full resolution.

The provider services operations team reviews the high-dollar inpatient claims denial report at least once monthly to make sure they have processed and paid correctly. If an error is found, the claim is adjusted, or the provider advocate will contact the hospital billing staff to educate and confirm proper corrections are made to resubmit the claim. High-dollar inpatient claims are typically over $100,000, and we confirm Providers are paid the full amount in a timely manner.

Figure 25-3. High-Dollar Claim Reviews



Our provider services team routinely reviews claim denial reports to identify where Providers may have had claims denied in error or made billing errors that resulted in denials reducing their payment. Our teams work these reports at least monthly. If UnitedHealthcare errors are found, the claims are automatically adjusted to pay the Provider the additional money owed. If we identify Provider billing errors to be corrected that will result in additional payment to Providers, the provider advocate will contact the Provider's office and assist in filing corrected claims or reconsiderations so the claim(s) can be adjudicated correctly. We will review Provider-specific denial percentage reports to identify and provide one-on-one support for denials, correction of claims and accurate billing for the future. Per **Scope of Services 7.6.6.G**, this service will be offered to Providers with a denial percentage of 25% or more; however, we will expand this support to Providers with lower denial percentages over time.

With planned expansion of this team, we aim to significantly reduce the number of adjustments and rework for Providers. Having additional full-time staff dedicated to monitoring State policy implementations means more precise and problem-free and fully audited loads in our system before the State effective date.

Training

Our Provider portal, *UHCprovider.com*, offers access to comprehensive, introductory and targeted training resources in all subject areas (e.g., the Provider Manual and transactional capabilities). The trainings are available on demand. In addition, our local provider trainer develops Provider training for all KanCare training needs. We offer a monthly Medicaid 101 session during our local KanCare Provider training for all Providers. In addition, we create and offer Provider-specific training as requested.

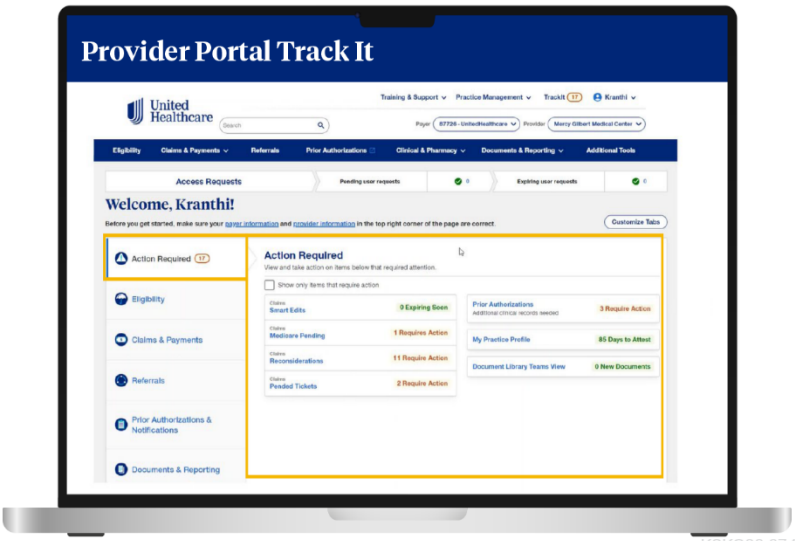
All newly contracted Providers and their office staff receive Provider education in multiple ways, including on-site visits, web-based training, Provider conferences, KanCare-specific training sessions, educational mailings and telephonic outreach. Training includes member eligibility, third-party liability, covered benefits, understanding claim denials and remediation, State policy changes, corrected claims, reconsideration and the appeals and grievance processes, navigating the Provider website and portal tools, and other pertinent topics.

- **Continuing Provider Education:** After the initial Provider training, our provider advocates are in frequent communication with our Kansas contracted Providers via phone calls, emails and in-person visits.
- **Program Enhancement and Targeted Training:** We encourage and welcome feedback from Providers, Provider associations and advisory councils on our training programs. We will continue to include these valuable partners on our Provider Advisory Committee and seek their input on training needs. Through these forums, we will identify broad-based communication and training opportunities for training with Providers. We will send training communication, as needed, to all Providers and update our training curriculum with the goal of further improving communication, especially on common issues such as changes in policies and procedures, billing and eligibility verification.
- **Support State's Training Efforts:** We work with other MCOs to create and present Provider training approved by the State quarterly at locations throughout the State. In addition, we participate in the CEO Forum semiannually to communicate with Providers.

Provider Portal and Online Tools

Our Provider portal streamlines communications through secure notifications and correspondence. With access to *UHCprovider.com* 24 hours a day, seven days a week, Providers can conduct business at their convenience. Our secure Provider portal is compliant with **Scope of Services 7.6.3.E.1**. The portal has a full suite of administrative tools for eligibility and claims. Providers can view and update demographic and roster information. Our **Track It** feature provides an integrated dashboard, where Providers have access to timely claims and denial information, including critical alerts and actions Providers need to take. Providers receive an email when claim status changes. Providers can access secure correspondence and notifications via the **Document Vault** the day they are generated so authorized users can view important information immediately. Documents are available for download for up to 24 months. Document Vault was developed based on Providers' feedback to ease administrative burden and reduce paper mailings.

Figure 25-4. Provider Portal Track It



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Based on Provider feedback in Kansas, new functionalities are coming soon to *UHCprovider.com*:

- We are implementing online scheduling in 2024 for Providers to schedule peer-to-peer reviews to be conducted within 24 hours based on the Provider's

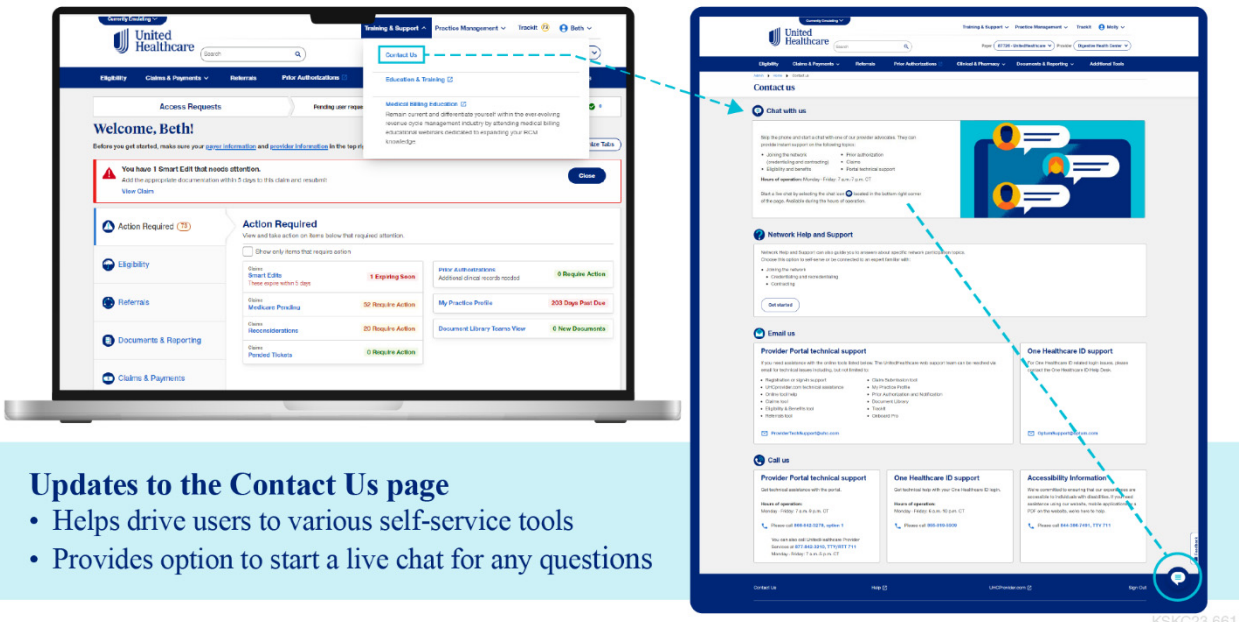
schedule. This effort will significantly reduce Provider wait time for scheduling and simplify administrative tasks.

- We are developing capabilities for Providers to submit all required documents with their initial claim submission via electronic data interchange (EDI) online.
- In 2025, we will add batch claims submission capabilities, credit balance, voids and Provider reporting.

Listen. Collaborate. Act.

We listened to feedback from nursing facilities and hospitals who were unable to submit claims electronically. Starting in 2023, hospitals and nursing facilities now have the capability to submit new or correct claims on the portal. As a result of this change, we addressed administrative burden, and institutions are receiving payment for claims faster.

Figure 25-5. Provider Portal Screenshots



Updates to the Contact Us page

- Helps drive users to various self-service tools
- Provides option to start a live chat for any questions

Provider Manual

Our Provider Manual is an online tool compliant with all KanCare requirements, and we educate Providers on how to use the Provider Manual during their initial and ongoing trainings. The Provider Manual is updated frequently to adhere to federal and State guidelines and Kansas.

Timely Claims Payment

We will exceed the contract requirements. The current average time to pay a clean claim is eight calendar days. We set a goal of an average time to pay all clean claims in five calendar days.

Listen. Collaborate. Act.

In 2023, RHC and FQHC Providers approached UnitedHealthcare leadership at a conference indicating they were seeing inconsistent processing of billed claims with specific POS codes. The local team implemented claims training and modifications to standard operating procedure within 30 days to improve claim processing accuracy with these POS codes. Feedback was shared, researched and we improved our claims standard operating procedure to enhance the consistency of processing.

Actions in Progress Based on Provider Feedback

We are actively listening to Providers and taking steps to ease administrative burden now and in the future. Key initiatives in progress are outlined as follows:

- **Overpayment and Recovery:** We are working with the payment integrity team to improve the recovery and recoupment process and improve timeliness in recovery turnarounds. In 2025, our secure portal will be updated with capabilities for voiding claims and paying outstanding accounts receivable balances. Our goal is to improve upfront editing and reviews by identifying the cause and preventing overpayments.
- **Prior Authorization:** We continue to review our KanCare prior authorization (PA) list to monitor utilization. We evaluate reduction in PA codes while maintaining the integrity of the services provided. As of November 2023, current turnaround time for nonurgent PAs is 3.26 days, and urgent PA turnaround is less than one day. **Our goal is to bring our overall PA turnaround time average to one day or less for all PAs.** We will continue to collaborate with MCOs and the State to streamline the PA process. We will develop advanced technology allowing direct connection to submit PAs directly into our system. In addition, to support Providers and their administrative staff, we are developing a PA reference document, including answers to FAQ and contact information for personal support. The goal is to improve PA processing time, simplify the process and reduce the number of appeals.
- **Gold Card Program:** [redacted]
- **Credentialing:** We will implement new processes to confirm all contracts are fully loaded within seven days of the Provider's credentialing passed date tomake sure Providers can see our Members and be paid for services promptly.
- **Simplified Contracting:** To improve timely, accurate payments and lessen administrative burden, we have adopted two new policies:
  - **Effectively treat Kansas Medicaid licensed Providers as in network.** This policy will reduce administrative time and result in more accurate and timely payment.
  - **Provider network enrollment date.** We are aligning network participation date with the Kansas Medicaid start date. This policy will simplify the experience for Providers with one enrollment date across MCO and State contracting.

Outstanding Customer Service

"I have worked with the KanCare Program since the initiation of the multiple insurance plans. Over the last 10 years, UnitedHealthcare has provided us with outstanding customer service. They do an excellent job of assisting with our questions, resolving billing issues, and always a resource to provide us feedback to requested information.

When I am unsure of a program requirement or a general question, my first person to reach out to is the Provider Relation Director in Topeka. Her knowledge of the Kansas Medical Assistance Program is excellent. UnitedHealthcare is fortunate to have her as part of their organization, and it filters down to the staff at UnitedHealthcare."

– Karen Hastert

Newman Regional Health

Provider Network

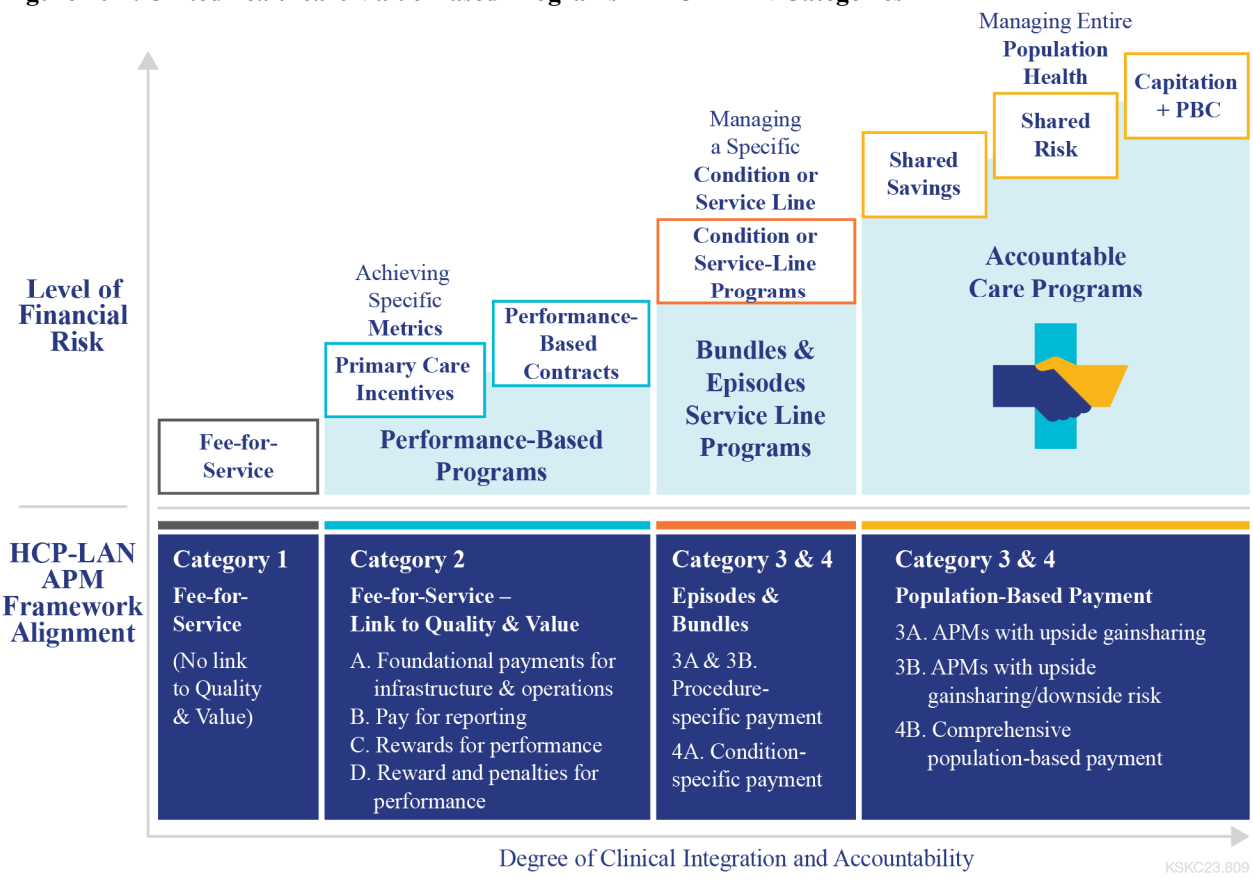
26. Describe the bidder's experience with developing and implementing value-based purchasing (VBP) arrangements designed to promote service quality, value, and outcomes over volume. Describe how the bidder will leverage its experience to successfully develop and implement VBP arrangements to improve the quality of care and Member health outcomes in KanCare. Include the following in the bidder's response:

Experience Developing and Implementing Value-Based Purchasing Arrangements

[redacted]

UnitedHealthcare is the top performing managed care plan in delivering value-based care in Kansas. We are relentless in our pursuit of continuous quality improvement and will continue to deploy our core capabilities in a graduated suite of value-based purchasing (VBP) programs using the Health Care Payment Learning and Action Network (LAN) APM framework shown in the following figure.

Figure 26-1. UnitedHealthcare Value-Based Programs in HCP-LAN Categories



We know from our experience that a one-size-fits-all value-based approach is not effective in Kansas. Providers are at varying levels of capacity and readiness for managing value-based programs. We educate Providers to understand how to effectively manage patient care in a value-based model, advance along the LAN continuum at a rate they choose and correct course when needed to keep Providers engaged. Approaching VBP this way works as evidenced by the following.

- Increased Provider participation in the Community Plan Primary Care Professional Incentive (CP-PCPi) program by **more than 300% from 2016 to 2022**
- Meeting over **70% of State-defined priority HEDIS® and Department of Aging P4P measures** and **outpacing our nearest competitor by more than 26 percentage points for 2021** (most recent year available)
- Creating one-of-a-kind VBP programs, such as our home modification and birth center incentive programs, to improve the health, safety and care of our Members

Keeping Home Modification Services Available in Western Kansas

In 2022, UnitedHealthcare received notice that Thrive Homes would no longer be able to provide home modifications in the rural most western part of the state. Together, UnitedHealthcare and Thrive Homes created a first-of-its-kind incentive program for home modifications, allowing Thrive to serve Members once again from Sedgwick County west to Colorado. This made all the difference to Janet, a UnitedHealthcare Member whose wooden ramp and handrail had collapsed, leaving her unable to safely leave her home. With advance funding from UnitedHealthcare, Thrive not only installed a safe ramp that will withstand the weather, but they also repaired Janet's brick molding and installed a new back door. Janet is thrilled that she can safely come and go from her home, saying these improvements have improved her quality of life.

a. The bidder's priority areas for VBP (e.g., Providers or populations) and anticipated outcomes.

Our Priority Areas for Value-Based Programs

We are aligning our value-based programs with the Kansas Department of Health and Environment (KDHE) Healthy Kansans 2030 State Health Improvement Plan (SHIP) goals to:

- **Improve inequities** in health and health outcomes, with improved Member engagement and identification of Member SDOH needs
- **Improve access to care** by making network participation more attractive to all Provider types, including behavioral health (BH)
- **Improve conditions that facilitate healthy behaviors** and health literacy through Member education, incentives to increase well visits for children and adults and engaging more Members in regular dental care

In addition to our current innovations in value-based care, our priorities include improving accountable care, providing incentives for BH follow-up care, improving access to dental wellness and supporting pharmacy Providers with medication therapy management programs.

Accountable Care Programs

Through new ACOs for PCP groups with over 1,000 assigned Members, we will focus on health inequities with care coordination and the careful selection of performance metrics. Designed to reduce unnecessary inpatient and ED utilization, our ACOs **outperform non-ACO Providers in 10 of 15 common core quality measures, including a 3.14% reduction in hospital readmissions**.

Anticipated Outcomes: The presence of a quality gate to shared savings in our total cost of care (ACO) models is critical to making sure quality is not sacrificed in the pursuit of cost or utilization reduction. The intent of the ACO program is not to withhold necessary care, but rather to eliminate avoidable or wasteful spend and improve population health. We anticipate growth in our overall shared savings models, based on Providers' willingness and readiness to move up the

risk continuum. As the level of risk increases, so does the opportunity for Providers to earn incentives and have a reduction in administrative requirements.

Behavioral Health Access

We have identified BH as a priority for developing value-based programs because seven- and 30-day outpatient follow-up from a hospital stay is proven to reduce readmissions.[1] In our BH Outpatient Shared Savings (OPSS) program, we will share Member admission and discharge information with the outpatient Providers who prioritize both seven- and 30-day follow-up appointments supporting community tenure.

Anticipated Outcomes: We expect a range of 3% to 10% improvement in follow-up care for our certified community behavioral health clinics (CCBHCs) who participate in our data-sharing/provider enablement consultation pilot that launched at the end of 2023.

Pharmacy Medication Therapy Management

Medication interactions and concomitant use problems are mostly preventable or predictable circumstances that may impact health outcomes. Clinical pharmacy activities such as medication therapy management (MTM) can identify and solve these problems, with potential to improve medication safety and effectiveness through education which reduces disparities through health literacy.[2] In 2022, we conducted 188 targeted adherence checks through the MTM program.

Anticipated Outcomes: [redacted]

Dental Home

We will implement our dental home model to promote network access, improve utilization, provide continuity of care and reduce dental emergency department visits. Members who have an established dental relationship will be assigned to a dental home based on their most recent 12 months of claims history. For Members who have not seen a dentist in the last 12 months, we will use ZIP code logic, in compliance with KDHE time and distance standards to assign each Member to a general or pediatric dentist.

Anticipated Outcomes: We anticipate our dental home and VBP program will drive a 2% to 3% increase in annual dental visits, periodic oral evaluations, prophylaxis, sealants and fluoride treatments. We will measure quality improvements using the Dental Quality Alliance measures established by the American Dental Association for oral evaluation, treatment services, preventive services and sealants to improve oral health, patient care and safety.

[1] Timely Outpatient Follow-up Is Associated with Fewer Hospital Readmissions among Patients with Behavioral Health Conditions | American Board of Family Medicine (jabfm.org).
[2] Impact of medication therapy management on pharmacotherapy safety in an intensive care unit - PubMed (nih.gov).

b. The bidder's proposed alternative payment models (APMs).

In accordance with **Scope of Services 7.7**, we make good faith efforts to enter VBP arrangements with Providers who request to participate. Prior to launching any VBP program, we submit proposed VBP arrangements to the State at least 90 Calendar days prior to implementation using the table in Scope of Services 7.7.F.1**.**

Our proposed APMs include our current suite of value-based programs and innovative programs designed to address the priorities described in our response to Question b.

Proposed Current Alternative Payment Models

Since our first Provider enrolled in our CP-PCPi program in 2016, we have grown that program and added others with Providers advancing along the HCP-LAN continuum. We propose to continue our current APMs, which include these programs:

Primary Care Professional and Obstetrics Incentive Program (CP-PCPi) – APM Category 2c

While KDHE determines the measures all managed care organizations (MCOs) must use for incentive programs, in 2022, UnitedHealthcare led a collaboration with all KanCare MCOs to present recommendations for future pay for performance measures to KDHE. Our directors of quality and reporting and analytics assembled a grid that considered HEDIS measures, Uniform Data Set (UDS) measures (to align with our federally qualified health center partners), State initiatives documented in the Healthy Kansans 2030 Report and measures such as immunizations that impact a substantial portion the population. We presented this information in a collaborative meeting with State leadership and look forward to shaping programs moving forward in the KanCare program.

Health Equity Provider Incentive Enhancement for 2024

Our Health Equity Provider Incentive (HEPi) program increases incentive payments to PCPs who reduce observed disparities in HEDIS measures between populations or regions. In the 15 States the program is active, PCPs closed over 54,851 HEDIS care gaps and earned over [redacted] in incentive payouts.

Future Enhancements: In 2024, we will add health equity measures to our incentives.

Program Description	Providers	Evaluation	Outcomes
Providers earn bonuses for closing gaps in care across key HEDIS® and CMS Core Set metrics, including behavioral health measures, chosen annually and aligned with KDHE's quality strategy.	PCPs with more than 20 assigned Members.	Bonuses are earned annually for achieving market performance targets or improving on past year performance.	[redacted]

Behavioral Health Provider Incentive Program (BHPi) – APM Category 2c

Much like the CP-PCPi program, this incentive is designed to support improved value, quality and advance Providers from volume to value. Providers can earn bonuses by helping Members become more engaged in their health care treatment.

Program Description	Providers	Evaluation	Outcomes
In Kansas, BHPi incentives peer support visits.	17 current Providers, several are CCBHCs.	Providers earn bonuses quarterly for each unique Member who receives one peer support visit per calendar year quarter.	**100% of Kansas Providers enrolled in BHPi earned bonuses.**

Free-Standing Birth Center – Quality and Cost of Care – APM Category 3a

The VBP for the free-standing birth center, New Birth Company in Overland Park, was the first of its kind in KanCare. Predicated on the focus for overall maternal health, in a setting that was chosen and appropriate for the mother, we forged this partnership to recognize this dynamic. The incentive includes two major components: quality and deliveries. The quality portion includes timely prenatal and postpartum care, and chlamydia testing.

Program Description	Providers	Evaluation	Outcomes
Rewards Provider for quality outcomes and delivery cost of care, targeted in Provider's coverage area of Johnson and Wyandotte counties.	New Birth Company	Bonuses are earned quarterly for achieving performance targets.	[redacted]

Condition-Specific Episodes of Care – APM Category 3a

In 2022, we expanded our VBP suite to include Episode of Care (EOC) incentives for specialists focused on high-cost conditions and procedures. When introducing EOCs, we determine which episodes and Providers to engage based on health trends within our KanCare population, utilization of services for target conditions and existing health disparities. Based on these criteria, we began our entry with asthma, maternity and diabetes EOC programs.

Program Description	Providers	Evaluation	Outcomes
For identified high-cost conditions and procedures, this program offers a retrospective shared savings opportunity based on the cost of care across a defined set of services and quality performance.	Specialists with more than 30 valid annual episodes.	Cost and quality are measured against historical baseline and improvement targets.	[redacted]

Proposed Future Alternative Payment Models

Building on our successful episode of care APM, we are planning for the next generation model where an entity pair, such as two Provider practices or a Provider and a CBO, co-manage a targeted episode. As part of the evolution of our maternal model, we will identify opportunities for an obstetrics group and doula organization to work together within our maternity episode of care program. We will launch the following programs in 2024:

Innovative Strategies for Southeast Kansas

"We look forward to continuing to impact individuals in Southeast Kansas through future innovative strategies involving NEMT and other potential value propositions. Through our work with UnitedHealthcare, it is clear they put the member first and are always seeking to make improvements to benefit these persons, as well as our facility and state partners."

– John Wesco, President, Community Health Centers of Southeast Kansas

Accountable Care Shared Savings and Risk Programs – APM Categories 3a and 3b

Our accountable care programs provide PCPs with technical and financial support for greater care coordination, management of population health, integrated behavioral health and total cost of care of their assigned panel. Practices must maintain open panels and offer extended hours for accessibility. We will build on the lessons we have learned through our Children's Mercy Pediatric Care Network (PCN) APM to inform future programs.

Program Description	Providers		Outcomes
Practices have an opportunity to earn a shared savings bonus by improving access to care and reducing unnecessary ED and inpatient utilization. Providers with shared risk are responsible for a portion of financial deficit incurred.	PCP groups with more than 1,000 assigned Members.	Cost and quality are measured against historical baseline and improvement targets.	Our PCN ACO has delivered these positive outcomes: **IP/1,000:** ACO population increased by 0.38% YOY and is 47.58% favorable compared to non-ACO population. **Readmissions:** ACO population utilization improved by 0.46% YOY and is 3.14% favorable compared to non-ACO population.

Outpatient Shared Savings – Behavioral Health – APM Category 3a

The Outpatient Shared Savings (OPSS) model is designed to support improved value, quality and advance beyond fee-for-service to pay for success programs. The OPSS model focuses on improving Member engagement in care, including for Members recently discharged from an inpatient behavioral health hospital. We know that timely seven- and 30-day follow-up appointments positively impact inpatient days. Providers share in savings generated by a reduction in the behavioral health inpatient spend of their attributed Members when they achieve target results on specific metrics.

Program Description	Providers	Evaluation	Outcomes
Addresses inappropriate inpatient utilization reduction; medicine adherence improvement; HEDIS gap closure.	Large behavioral health outpatient Providers.	Cost and quality are measured against baseline and improvement targets.	Five active Providers; most recent measurement period saw a seven-day follow-up from hospitalization improved 6% from baseline; 30-day improved 10% from baseline; medication adherence improved between 2% and 6% from baseline.

Pharmacy Medication Therapy Management – APM Category 2c

Using retail pharmacies to provide medication therapy management (MTM) improves Member health outcomes. We partner with OptumRx to deliver and assist in administering this program.

Program Description	Providers	Evaluation	Outcomes
Pharmacies receive payment based on comprehensive medication reviews and targeted intervention program services.	Pharmacists at retail pharmacies.	Monthly payments for documentation of clinical interventions.	[redacted]

Dental Incentive Program – APM Categories 3a and 3b

To increase Member access to diagnostic and preventive dental services, dental Providers can participate in our dual incentive models beginning in 2024. These models provide flexibility and scalability for Providers while shifting the focus of the dental delivery system toward diagnostic and preventive care, improved care coordination and reduction of adverse outcomes and disparities.

Program Description	Providers	Evaluation	Outcomes
Quality metrics aligned with KDHE and Department of Health Oral Health Care priorities.	Selected participation, geographic diversity.	Cost and quality are measured against the number of dental home Members assigned to the Provider.	Measurement of diagnostic and preventive care, annual visits, oral evaluation leading to appropriate care, such as dental sealants.

c. The bidder's approach to identifying and supporting KanCare Providers to implement VBP arrangements.

Identifying and Supporting Providers to Implement Value-Based Purchasing Arrangements

Our health care economics and Provider network teams continually evaluate practice-level data to identify Providers who may be appropriate for value-based programs.

Identifying Providers to Implement VBP Programs

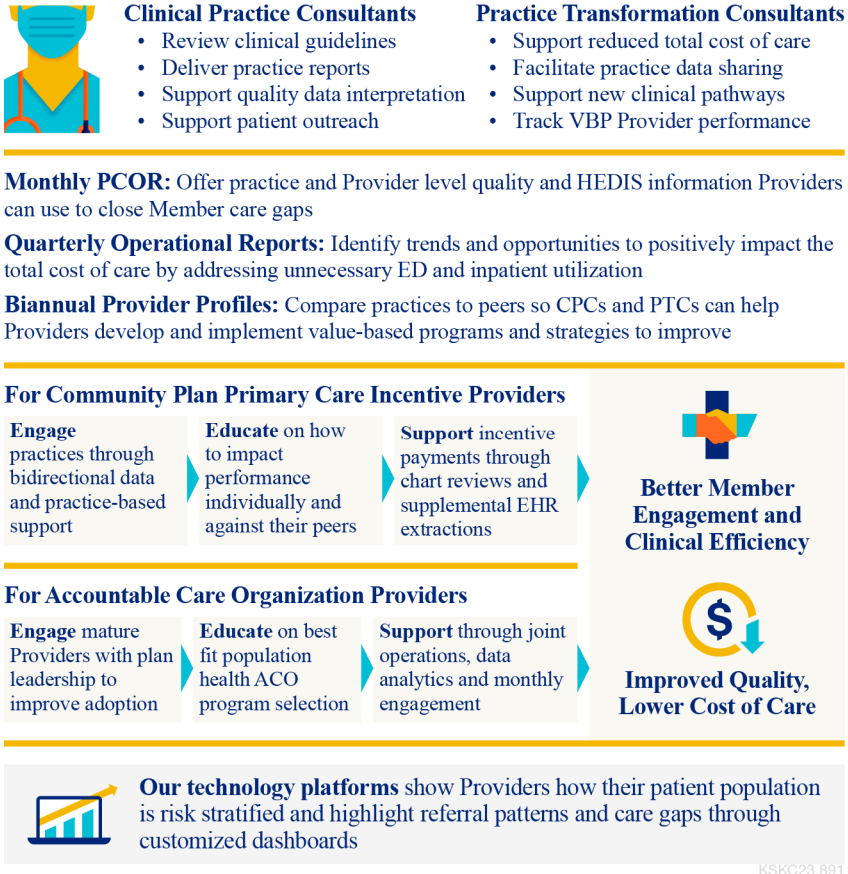
We assess each practice's degree of clinical and financial integration, commitment to and investment in population health management and information technology capabilities. These data points identify Providers whose data indicates a level of readiness for value-based programs:

- **Member panel size and stability:** We evaluate a Provider practice's panel size to align a VBP model with the Provider.
- **Cost of care analysis:** We collect at least 12 months of recent claims data and compare costs in consideration of the enrollment mix the practice serves. This analysis sets the stage for reviewing the outcomes data internally and determining which Providers to approach.
- **Quality performance:** We review the Provider's quality performance, including care gap closures, and use this information to set realistic performance improvement thresholds.
- **Relationship and readiness:** We identify the Provider's existing VBP agreements with our other lines of business. Our team engages in active discussions with any Provider, including Provider-based associations who wishes to explore a VBP.

Supporting Providers Who Implement Value-Based Purchasing Programs

Our value-based programs sit on a foundation of health information technology tools, data and reports that allow our leaders, staff and Providers to know the status of the practice and population. We know too that hands-on support is foundational to success in VBPs. Our executive leadership team partners with Providers to assess their willingness and readiness to engage in value-based care. They evaluate all payment models and together select programs for

Figure 26-2. Value-Based Provider Practice Supports



implementation. Our practice-based staff helps Providers identify and close care gaps and learn value-based strategies as they advance along the APM continuum. Together, these activities form a successful value-based Provider strategy.

d. The bidder's strategies to reduce administrative burden for participating Providers.

Our Strategies for Reducing Provider Administrative Burden

Simplifying the Provider experience and reducing administrative burden improves recruiting and retention efforts and participation in value-based programs.

To reduce Provider administrative burden in VBP programs, we use the following strategies:

- **Delivering advance incentive** funding to support tailored practice transformation and capacity building. **Our $100,000 investment in Community Health Center of Southeast Kansas** (CHCSEKS) reduced CHCSEKS burden of meeting ongoing expenses.
- **Aligning quality measures** with KDHE, KDADS and Public Health means Providers have fewer sets of standards to meet.
- **Sharing data** insights in an intuitive format through customized dashboards and detailed claims data for Providers who prefer to run their own analytics reduces practice staff time in finding the data that matters most to that practice.
- **Supporting Provider staff** with practice-based resources enhances patient care quality and cost efficiency.
- **Reducing prior authorization burden** by implementing Gold Card program in 2024. [redacted]

UnitedHealthcare Support is Instrumental in PCN Success

"UnitedHealthcare has been instrumental in our success as an important partner. The Pediatric Care Network community practices participate in a value-based incentive model and shared savings opportunity The focus is to improve health care delivery in the region by achieving cost efficiency in the provisions of health services."

– Pamela Johnson, Director ICS Medicaid OPS & Population Health Network Mgmt.

e. How the bidder will measure, monitor, and evaluate the effectiveness of the payment arrangements and outcomes.

Measuring, Monitoring and Evaluating Value-Based Program Effectiveness

As a part of our commitment to continuous quality improvement, we monitor, measure and evaluate our program at the overall VBP program, APM and Provider levels.

Monitoring Value-Based Program Effectiveness

Working with Providers, we monitor performance monthly, quarterly or annually as appropriate for Provider experience and program. We select measures that align with State quality strategies, incentives and sanctions.

Primary care incentive monitoring: We design our quality incentive models to support practices in achieving improvement in patient health outcomes through closing gaps in care related to preventive screenings and chronic disease monitoring and the opportunity to be

rewarded for their performance. Practices may earn bonus payouts in addition to their fee-for-service reimbursement for meeting or exceeding quality measure thresholds. This approach has resulted in a **300% CP-PCPi program participation increase since 2016.**

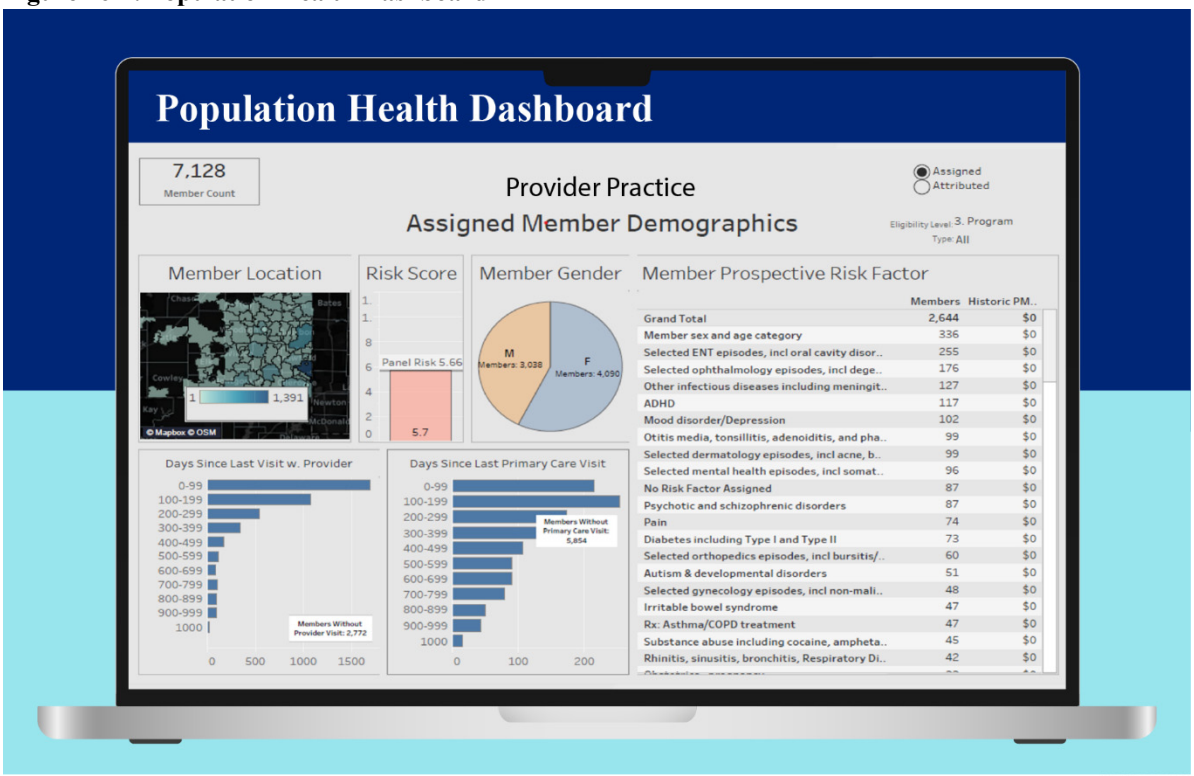
[redacted]

ACO monitoring: In our total cost care or ACO models, the presence of a quality gate to shared savings is critical to make sure quality is not sacrificed in the pursuit of cost or utilization reduction. The intent of the ACO program is not to withhold needed health care services. We seek to eliminate avoidable and wasteful spend and improve population health. This effort reduces future health care risk and cost, leaving us with a more sustainable health care system for payer, Provider and patient needs.

Measuring Value-Based Program Effectiveness

We evaluate our programs based on improvements in quality, health equity and Member health outcomes important to Kansas Medicaid Members and State goals. We will accomplish this through partnerships with Kansas Providers in a variety of VBP programs, deploying flexible models that empower Provider-led decision making, reward primary, preventive and integrated care and appropriate use of the health care delivery system. One of the tools we use to help Providers understand the effectiveness of value-based programs is our population health dashboard, shown in the following figure.

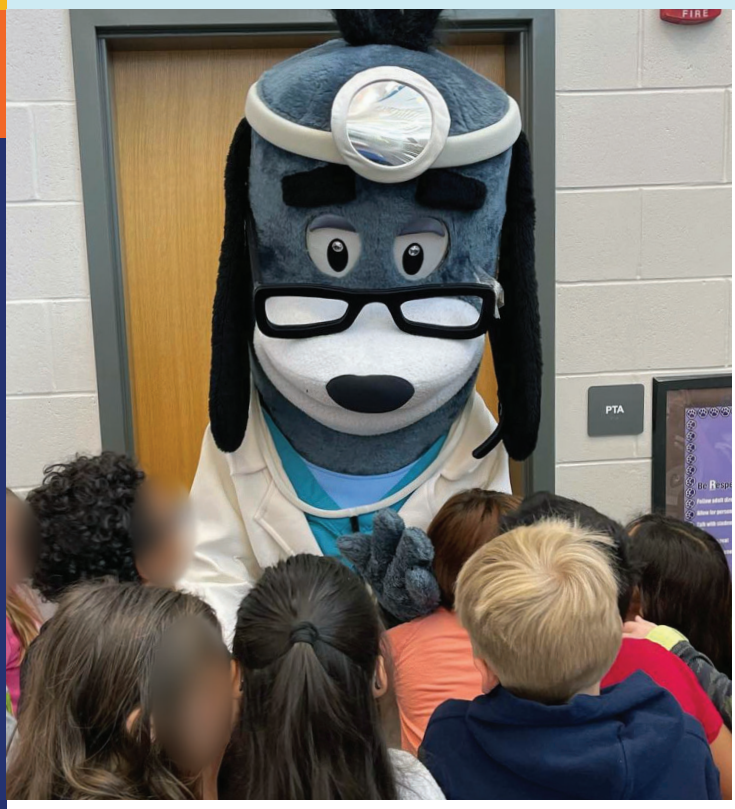
Figure 26-4. Population Health Dashboard



Evaluating Value-Based Program Effectiveness

We evaluate the overall success of our VBP strategy by Provider willingness to engage and participate in these programs and the quality and cost of care results these programs deliver, such as episodic health outcomes, utilization, engagement and total cost of care. We measure VBP performance as a tool to support our Population Health and Health Equity framework and clinical initiatives.

Case Scenarios (Tab 7g)



Encouraging Dental Hygiene for Students in Olathe

Dental habits can impact kids' health and well-being. That is why we collaborate with Health Partnership Clinic, a federally qualified health center in Olathe, to host an annual Dental Health Coloring Contest to inspire students to learn healthy dental habits. We celebrated with a pizza party and prizes for students at six Olathe Public Schools.

Kansans United

United Healthcare Community Plan

Case Scenarios

27. The bidder's Member services line receives a call from Maria, the mother of a twenty-two (22)-year-old, Hispanic, female KanCare Member named Juanita. Maria's and Juanita's primary language is Spanish. Juanita delivered a baby boy approximately two (2) weeks ago. Maria is calling out of her concern for the well-being of her daughter and grandson.

Maria shares that the Member has been living temporarily with her until Juanita finds employment, transportation, childcare, and housing. Maria states while Maria works, she has been struggling to make ends meet and at times has been unable to buy groceries. Maria shares that she has recently noticed significant and increasing changes in Juanita, including bouts of crying, lack of appetite, listlessness, and frustration with caring for her baby. Maria reports that Juanita has not been sleeping much and is struggling to produce enough breast milk to meet the baby's needs. Maria thinks that the baby may be "colicky" because the baby "cries a lot" and is difficult to soothe. Maria stated that Juanita missed the first postpartum well check because the baby was finally sleeping, and Juanita did not want to wake the baby. Maria immediately called the Member services line when her daughter told her, "I can't do this anymore."

Describe how the bidder will handle the call from Maria, and the bidder's approach to meeting the needs of Juanita and her baby.

Wyandotte County, where Juanita and her family reside, is the poorest county in Kansas.[1] According to the maternal vulnerability index, women in Wyandotte County are more vulnerable to adverse maternal health outcomes due to socioeconomic determinants of health such as educational attainment, poverty and food insecurity, and social support. All these things impact Juanita and her family and are complicated by English not being their primary language.

UnitedHealthcare's approach to providing integrated, whole-person care and support to Juanita and her family is informed by our experience nationally and in Kansas where, **since 2021, we have served more than 500 pregnant Hispanic Kansans, on average, annually.** Our Healthy First Steps (HFS) maternity care coordination program's approach focuses on meeting Juanita's and Mateo's needs in a culturally humble and competent manner, making sure we assess and respond in a timely manner to her mental and emotional needs, assess and meet her physical and social needs, and pair her with appropriate resources that support her and her family with culturally competent access to education, employment, housing and childcare resources.

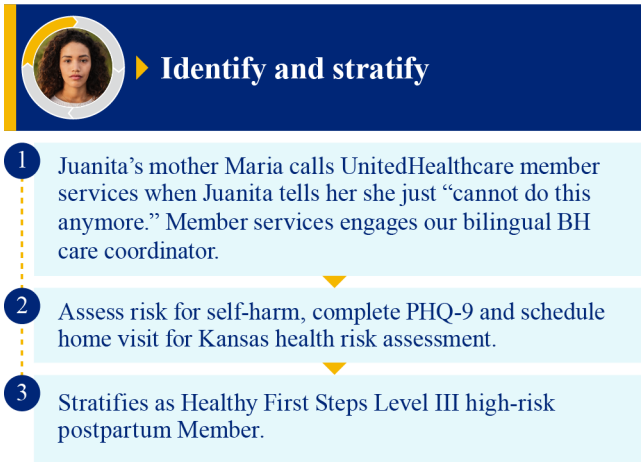
[1] Healthy Kansans 2030.

When Juanita was first enrolled with UnitedHealthcare she was early in her first trimester of pregnancy. She was living with her boyfriend and having a normal, healthy pregnancy. She was enrolled in HFS at a low level of risk and participated in monthly care coordination by phone. HFS is a comprehensive program designed to ensure the well-being of pregnant Members and their babies. The program offers care coordination and supports pregnant Members with assistance in scheduling appointments, managing the Member's pregnancies and providing educational materials on nutrition, breastfeeding and baby care. It also helps with access to resources such as transportation and housing, making it easier for Members to focus on their health and the health of their baby.

Late in Juanita's third trimester, her HFS RN care coordinator was unable to reach Juanita by phone and sent a text to the phone number we had on file. Concerned for Juanita, the HFS RN made a visit to the apartment Juanita shared with her boyfriend and learned the couple had separated and both had moved out of the apartment. The new occupants did not know where Juanita went or how she could be reached.

Identify and Stratify

Early this morning, when Maria, Juanita's mother, woke to find Juanita and Mateo both crying and heard Juanita's claim that she just "cannot do this anymore," she called into UnitedHealthcare's member services line. Through our interactive voice response (IVR) system, Maria selected "Spanish" when prompted. Like the other 5,400 Spanish language calls through our Kansas member services team since 2022, the system automatically routed the call to one of our Spanish-speaking member service advocates (MSAs). The MSA confirms Juanita as a UnitedHealthcare Member and Maria as her authorized representative with a signed release of information on file. Maria details the situation to the MSA who then asks to speak to Juanita.



When Juanita joins the call, the MSA notes signs of mild distress in Juanita and recommends she be connected right away through a warm transfer to one of our BH care coordinators who uses Language Line while assessing Juanita's crisis risk and risk of harm. Juanita confirms that she does not have homicidal or suicidal ideation and is not harming herself. She says both she and Mateo are safe. Knowing there is no immediate crisis, but there is a significant change in condition, the BH care coordinator uses our care coordination system, CommunityCare, to identify and contact Juanita's HFS RN who speaks Spanish and was previously assigned to Juanita. The BH care coordinator lets Juanita know she should expect a call from the HFS RN within 24 hours.

Due to Juanita's risk factors, the HFS RN schedules immediate outreach. The HFS RN connects with Juanita by phone and arranges to visit her at home later in the day. When the HFS RN arrives at the home, Maria is at work and Juanita is walking the floor with a finally settling Mateo. Juanita places Mateo in his crib where he fusses but does not cry. Together, they complete the HFS postpartum assessment, the Kansas health risk assessment (HRA) and the PHQ-9 (Patient Health Questionnaire-9) depression screening tool. After receiving a PHQ-9

score of 13, the HFS RN recognizes that Juanita is experiencing moderate emotional distress, and again confirms Juanita has no plan or thoughts of harm to herself or Mateo. Based on the assessments and the clinical presentation, the HFS RN recognizes that Juanita could benefit from a further assessment by a BH professional.

Knowing that Juanita has said she is worried Mateo is not getting enough nutrition, the HFS RN asks Juanita a series of questions designed to confirm Mateo is getting enough to eat and drink. The HFS RN confirms Mateo has eight wet diapers each day and has transitioned to seedy breastmilk stools with every feeding. He feeds every two and a half to three hours by breast, and Juanita does notice a change in the feeling of her breasts after he eats but says she does have some pain while nursing. The HFS RN reassures Juanita that Mateo appears to be getting enough breast milk but suggests a consultation with our Spanish-speaking certified lactation consultant (CLC) to address the pain.

Engage and Meet Urgent Needs

Following completion of assessments, Juanita and her HFS RN identify the following as her most pressing needs:

- Making sure the family has adequate food
- Scheduling a BH therapy appointment to address Juanita's feelings of sadness and inadequacy
- Rescheduling Juanita's postpartum appointment with her OB/GYN
- Connecting Juanita to a CLC to address the pain during Mateo's feedings
- Scheduling Mateo's pediatrician appointment

To support Juanita's immediate nutrition needs, the RN orders Mom's Meals, a UnitedHealthcare value-added benefit (VAB), which is a set of 14 pre-made culturally aligned meals delivered to her door, and a food grocery box to support the family. Since Juanita already has Women, Infants and Children (WIC) and is a supplemental nutrition assistance program (SNAP) beneficiary, the HFS RN uses Findhelp to identify food pantries in Juanita's area and shares the list of locations through text along with the delivery information from Mom's Meals.

The HFS RN refers Juanita to our Spanish-speaking CLCs to help her with the pain she is experiencing during Mateo's feedings. Our Spanish-speaking CLC has provided services to the community since 2018. The CLC schedules a virtual meeting with Juanita to provide her with education about the importance of hydration on breastmilk production, provided tips on how to address her pain between feedings such as gently massaging the sore area before nursing, use wet or dry heat on breasts before feeding, instructions on how to use the breast pump she obtained at the end of her pregnancy and how to connect with the counselor when she has questions.

The CLC also asks Juanita if she remembers learning about the Period of PURPLE crying at AdventHealth, where she delivered Mateo. Juanita vaguely remembers hearing about it, but

confesses she was too tired to pay attention. The HFS RN explains that Mateo is two weeks old, and this is often when this period starts. The Period of PURPLE crying is a research-based education program developed by the National Center on Shaken Baby Syndrome to educate parents about normal infant crying. The CLC explains that PURPLE is an acronym that stands for peak of crying; unexpected; resists soothing; pain like face; long lasting; evening crying. The CLC explains how crying may increase and last for several hours for no apparent reason and that it is okay to place him in his bassinet and walk away for brief periods when crying is too much.

The HFS RN educates Juanita about the impact that pregnancy and the postpartum period can have on emotional and behavioral health, and the different supports available, which include talk therapy and/or medication. The HFS RN knows there is stigma about BH in the Hispanic community and uses cultural humility, active listening and motivational interviewing to build rapport and help Juanita open up about her needs and see the value in BH services. Juanita expresses appreciation that the HFS RN listened to her story and agrees to try talk therapy. The HFS RN conducts a three-way call with Vibrant Health, a federally qualified health center, and helps her schedule a therapy appointment on the same day that Mateo will see his pediatrician there, reducing the number of trips.

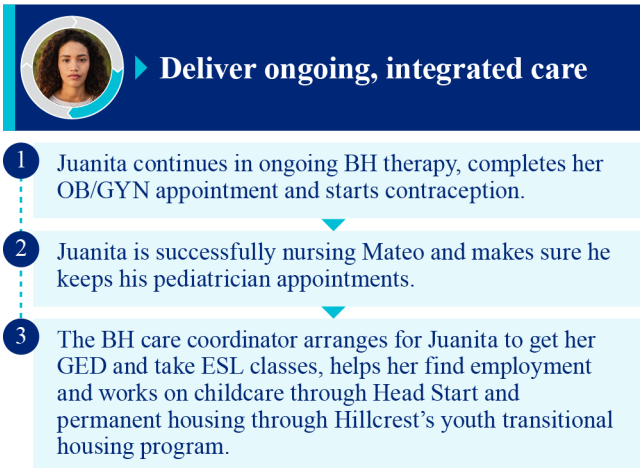
Juanita and the HFS RN look at the Vibrant Health location, which is conveniently located along the bus line. Because of the location, Juanita states she would prefer to use the bus instead of taxi services. The HFS RN assists with ordering bus passes for Juanita and helps to arrange for transportation to her other appointments where bus service is less convenient. Since Juanita lacks reliable transportation, the HFS RN reminds Juanita that she can use the UnitedHealthcare transportation VAB for 24 round trips for nonmedical needs, such as going to the grocery store or farmer's market. [redacted]

While at Juanita's home, the HFS RN calls Juanita's OB/GYN's office. The HFS RN asks to speak to an OB/GYN nurse and explains that Juanita has an elevated PHQ-9 score and needs an appointment urgently. The OB/GYN nurse schedules Juanita for a virtual visit for later that afternoon to complete a more in-depth postpartum depression screening. The HSF RN shows Juanita how to access our Language Line to have support during this and any future medical appointments. With the support of an interpreter, the OB/GYN's nurse completes the screening and determines that Juanita does not have postpartum depression but would benefit from BH support. Before finishing the virtual session, the OB/GYN's nurse schedules an in-person follow-up visit in two days when Juanita will have a complete postpartum visit and discuss her options for contraception.

Juanita and the HFS RN schedule a follow-up call for the next week to make sure Juanita is accessing all the services she needs and to check on her mental and emotional health. Once care is re-established with Juanita's Providers and she feels better, the HFS RN will call Juanita at least every 30 days for her 12-month postpartum period. The HFS RN reminds Juanita, she can call any time she needs help or has questions or concerns.

Deliver Ongoing, Integrated Care

In the weeks after the HFS RN's home visit, Juanita has established a routine in caring for Mateo. Mom's Meals provided the bridge Juanita and Maria needed to secure longer-term nutritional supports. Accessing her WIC and SNAP benefits and using her VAB transportation has resolved many of the family's food concerns. The CLC helped Juanita with breastfeeding techniques to relieve the engorgement the CLC suspects may be the cause of her pain and provides education on some foods to avoid such as beans and spicy foods, which may give Mateo gas. Since eliminating those foods, Mateo has been less fussy and is sleeping more regularly and for longer periods, helping to reduce Juanita's stress level.



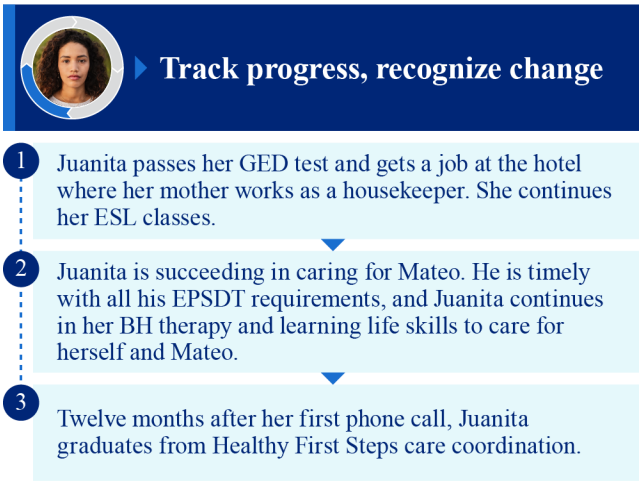
Juanita relays that the therapist at Vibrant has helped her feel more optimistic and is working with her on some coping skills to manage her stress. Juanita was not diagnosed with postpartum depression, but the therapist and OB/GYN are keeping a close eye on her through regular check-ins and follow-up appointments. Juanita can once again begin to think about what is next for her and Mateo — a job, childcare and a place of their own. Juanita confirms she is keeping up with Mateo's well-child visit appointments at Vibrant and that he is getting all of his vaccinations.

Our HFS RN will use internal and external resources, such as the following, to wrap Juanita and Mateo with the necessary support to maintain wellness and success on her goals.

- **Ongoing Food Security:** Once Juanita's immediate food access needs are addressed, the RN will suggest Juanita enrolls in SNAP-Ed classes, which are available in English and Spanish. Through these classes, Juanita and Maria will learn about healthy eating on a small budget and once the six-week class is completed, Juanita will be eligible for the $50 VAB, which she can use to purchase an electric skillet to help her prepare meals at home.
- **Double Up Food Bucks for SNAP:** The HFS RN provides education about the Double Up Food Bucks for SNAP when purchasing at specific stores and farmer's markets. Double Up allows Juanita to double her benefits for fresh fruits and vegetables.
- **Early Childhood Education Support:** Using the Integrated Referral Intake System (IRIS), the HFS RN links Juanita to maternal and child services. IRIS is a Provider-led bidirectional referral platform that provides a streamlined process for coordinating referrals between partners across various sectors. Because parents are their child's first and most influential teachers, Juanita wants to learn how best to teach Mateo. Juanita's HFS RN connects her to Head Start at Project Eagle in Wyandotte County. Head Start emphasizes not only children's cognitive development but also their social, emotional and physical development, and has a strong parent involvement component.

- **Employment:** Our employment and education specialist (EES) helps Juanita access our educational VAB of $200 to support her educational and employment goals. Juanita shares that she does not have her high school diploma. Our EES helps Juanita enroll in Spanish general educational development (GED) and English as a second language (ESL) classes at her local public library. Juanita uses her transportation VAB to access these classes. Juanita shares that when Mateo is three months old, she would like to obtain a part-time job. We connect Juanita with workforce partnership in Wyandotte where Juanita receives skills-based placement help to find a job where she does not need to speak fluent English.
- **Housing:** Juanita shares with her HFS RN that extended family living is a tradition in her Hispanic community. She says that like many young women with children she will live with her mother so they can work together to fund the family's needs and provide childcare for Mateo. For now, Juanita is grateful to have her mother nearby but wants to move out within the next year or so. Transitional housing may give Juanita the best chance of getting out on her own. After learning about the Hillcrest transitioning housing program, Juanita agrees Hillcrest will be a good fit for her. Hillcrest offers a housing and life skills program aimed at helping youth transition to successful adult independent living. Hillcrest accepts youth ages 16 to 24 from the Kansas City Metro area. Juanita will have her own furnished living space with utilities included. A food pantry and laundry facilities are on-site. In addition, Juanita will have a support team focused on helping her achieve her educational goals, find a job, manage her finances and learn how to lead a productive and healthy adult life.

Track Progress, Recognize Change



Juanita's HFS RN will continue monthly outreach by text and phone per Juanita's preferences. Using the population health dashboard in CommunityCare, the HFS RN makes sure Mateo is receiving his EPSDT exams and immunizations on schedule. The HFS RN educates Juanita about the use of the 24 hours a day, seven days a week NurseLine to avoid ED visits for nonemergent health issues and assesses Juanita at each call using the PHQ-9. Juanita shares that she is working through her fears of single parenting and is feeling emotionally stronger every day. Juanita shares that Maria has been helpful in watching Mateo while she completed her GED using the educational VAB and now while she participates in her ESL class. With the skills she developed through the workforce partnership, Juanita is about to get a job at the hotel where her mother worked as a housekeeper. She is excited about the English she is learning at the ESL class and hopes that as she becomes more fluent, she can use her GED to obtain a job that will allow her to make more money.

After a year, Juanita and Mateo moved into Hillcrest where she is learning life skills such as personal finances, getting a driver's license and parenting. Her and Mateo's medical, BH and social needs are being addressed and Juanita feels like she has built the skills necessary to build a healthy, happy life for her family. Juanita is ready to graduate from the HFS care coordination program. The HFS RN reminds her that she can still call — any time she needs help or support. We will continue ongoing risk stratification for both Juanita and Mateo monthly to identify any new or emerging risks. If, at any time, either experiences a significant change in condition, we will initiate care coordination outreach, as needed.

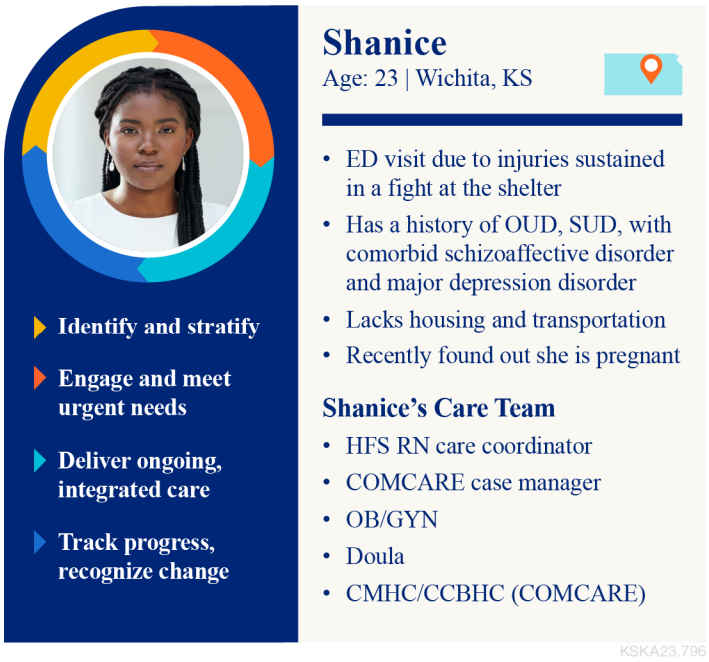
Case Scenarios

28. Shanice is a twenty-three (23)-year-old, black, female KanCare Member who was brought to the Emergency Department (ED) by police due to injuries sustained during a fight with another person in a downtown homeless shelter. While her injuries do not appear to be life threatening, Shanice sustained injuries around her face and head and exhibits odd behavior.

Shanice has a history of opioid use disorder, benzodiazepine use disorder, and stimulant use disorder in addition to co-morbid schizoaffective disorder and major depression disorder with psychotic features. Her drug screens at the ED are positive for opioids and benzodiazepines. Shanice has been receiving services through a CCBHC, but has been inconsistently engaged in treatment and has presented to the ED multiple times for either drug intoxication or withdrawal in the past year. She is unstably housed and lacks any form of Transportation. Tests conducted during the ED stay indicate that Shanice is pregnant.

Describe the bidder's approach to addressing Shanice's needs.

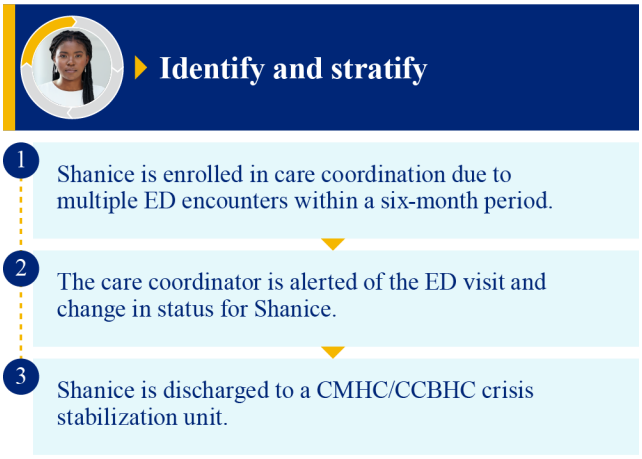
Shanice's case reflects one of the State's top health priorities — improving inequities in health and health outcomes. According to the Healthy Kansans 2030 State Health Assessment Report and 2022 Kansas Maternal Mortality Review Report, Black pregnant individuals have a mortality rate 2.5 times higher than non-Hispanic white individuals and 3.5 times higher than Hispanic pregnant individuals, with mental health, substance use disorders (SUDs) and opioid use disorders (OUDs) increasing vulnerability.



UnitedHealthcare's approach to providing integrated, holistic care to Shanice is informed by our experience nationally and in Kansas where, since 2021, **we have served more than 600 pregnant Kansans with SUD and/or OUD annually**. Prompt identification of KanCare Members who are pregnant is critical to providing care and achieving optimal birth outcomes. Shanice's engagement in care and discovered pregnancy is a pivotal time for us to engage.

Through our Healthy First Steps (HFS) maternity care coordination model, we build trust to increase the engagement of pregnant Members with complex BH, SUD and OUD challenges like Shanice — to provide the helping hand and pathway to better health that Shanice needs for herself and her baby. Healthy First Steps promotes routine OB/GYN care and enhances Provider-patient relationships and care plan adherence. This program is driving improved birth outcomes for Kansans. Year-to-date in 2023, **the Kansas neonatal abstinence syndrome (NAS) average length of stay (ALOS) is 10.6 days, 25% shorter** than our national NAS ALOS.

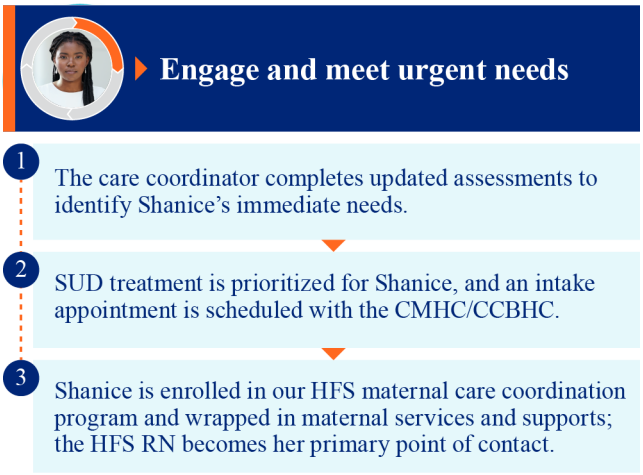
Identify and Stratify



Shanice is an existing Member, enrolled in care coordination due to her multiple ED visits and complex BH needs (diagnosis of major depressive disorder, schizoaffective disorder, OUD and SUD), placing her at greater risk of mortality and adverse health outcomes. Shanice was assigned to a care coordinator after visiting the ED on two separate occasions within a six-month period. The assigned care coordinator is experienced in collaborating with Members with BH needs and trained in trauma-informed care. The care coordinator has been unable to reach Shanice for the last two months, despite coordinating with her COMCARE of Sedgwick County, a Community Mental Health Center/Certified Community Behavioral Health Clinic (CMHC/CCBHC), case manager who has also been unable to contact her.

Her assigned care coordinator receives an alert in our care management system, CommunityCare, about Shanice's visit to the ED at Via Christi in the Wellington area and queries the Kansas Health Information Network and KONZA National Network (KHIN and KONZA) for additional health information available concerning the Via Christi ED visit. The care coordinator learns of Shanice's substance use screening results, that she is pregnant and is discharged from the ED to COMCARE's Crisis Stabilization Unit (CSU) in Wichita, which provides a safe, structured environment as an alternative to psychiatric hospitalization. With updated contact information and a known location, the care coordinator makes a call to the CSU to speak with Shanice, who agrees to an in-person visit the following day.

Engage and Meet Urgent Needs



The next day, the care coordinator meets in person with Shanice at the CSU to update her assessments and plan of service as she is experiencing exacerbation of her BH symptoms and SUD. The care coordinator asks Shanice if she can answer questions about her overall health and challenges, and her hopes for the future, so that they can work together to help her achieve her goals. Shanice agrees and states she is motivated to provide a safe home for her baby, but she is concerned that her substance and opioid use may adversely affect her baby.

Using trauma-informed and motivational interviewing techniques, the care coordinator seeks to understand Shanice's needs, including what has changed since they last connected and the underlying reason(s) for her housing challenges, substance use and other circumstances. Confirming Shanice completed a Health Screening Tool (HST) in the last year, the care

coordinator proceeds with completing a new health risk assessment (HRA) due to the change in Shanice's condition related to her pregnancy and SUD. The HRA is a comprehensive assessment covering medical, BH, pharmacy and social determinants of health (SDOH) needs.

Shanice shares that she has not been regularly attending her appointments at COMCARE. Shanice confides she has been avoiding calls from her COMCARE case manager because she is ashamed of her situation. The care coordinator listens to Shanice and asks her to elaborate on the challenges to keeping these appointments. She shares her sister kicked her out about a month ago due to her substance use, and she has been staying on the street or in a shelter since. The care coordinator expresses concern and empathy for Shanice's situation, sharing that while her pregnancy is a priority, the first step is to stabilize Shanice and reestablish a connection to the CMHC/CCBHC for continued BH support and SUD treatment so she can deliver a healthy baby. Shanice understands and agrees to an appointment with COMCARE. The care coordinator offers to connect with Shanice's case manager at COMCARE and help get an appointment scheduled within the week to reestablish care. Shanice agrees and states she appreciates the help.

During this face-to-face visit, the care coordinator reviews the nonemergency transportation benefits with Shanice, emphasizing that these benefits allow her to receive no-cost transport for prenatal visits, BH appointments, trips to the pharmacy for medication and transportation to SUD treatment. [redacted] Transportation Hub is accessed through the landing page on our *myuhc.com* Member portal and through our mobile app using a smartphone. In addition, Shanice receives UnitedHealthcare value-added transportation benefit information (i.e., 24 round trips to address nonmedical-related needs such as going to recovery meetings).

The care coordinator discusses temporary housing options with Shanice because her CSU stay is limited to five days. Shanice is interested in moving into an Oxford House, a peer recovery house for women to support her in maintaining sobriety while she pursues long-term housing. The care coordinator works with our housing navigator and secures a spot at one of the Sedgwick County Oxford houses. Shanice plans to move to the Oxford House the following day.

Shanice mentions that she no longer has a cellphone and no way to communicate with the care coordinator, her COMCARE case manager or her Providers. The care coordinator orders a SafeLink government phone for Shanice, to be delivered to her at the Oxford House. SafeLink is a government benefit that provides free telephones to those in need. In the meantime, Shanice agrees to communicate through the Oxford House phone.

The care coordinator explains to Shanice that because she is pregnant, she is eligible for our HFS maternity care coordination program, which can provide additional wraparound support to help coordinate her BH and pregnancy needs. The HFS program aims to improve maternal and child outcomes by identifying and engaging Members as early as possible in their pregnancy and by supporting Members with addressing their health and social needs. The care

HFS Addressing Disparities

In 2021, UnitedHealthcare identified Sedgwick and Wyandotte counties as areas where low birth weight and NICU rates were higher, and where deeper disparities between white and Black families existed. The average NICU rate for our membership in Kansas is 8% to 9%, **while the average NICU rate for Sedgwick and Wyandotte counties was 11%.** Based on this data, UnitedHealthcare increased HFS engagement efforts in these counties by adding Members with rising risk to our outreach efforts and provided additional staff training on health equity.

coordinator explains that the HFS RN will become her primary point of contact for care coordination support, but they will continue to coordinate with the COMCARE case manager and the BH care coordinator as needed. Shanice is apprehensive about working with someone new. Together with Shanice, the care coordinator calls the HFS RN to make an introduction. The HFS RN shares that they are from Wichita and familiar with the community resources available to help pregnant Members like Shanice, that they are a bachelor's-level nurse with expertise in perinatal and NICU care and experienced in caring for Members with BH diagnosis. Shanice is grateful for the support and eager to engage in the program so she can meet her goals of a healthy pregnancy and providing a safe place for her baby. The HFS RN plans an in-person visit in one week after Shanice's appointment at the CMHC/CCBHC.

Shanice attends the scheduled CMHC/CCBHC appointment at COMCARE. While there, the Qualified Mental Health Professional (QMHP) identifies through the assessment process that Shanice is at elevated risk for relapse and recommends enrollment in intensive outpatient treatment. They prioritize her SUD treatment, providing access to buprenorphine, due to its safety profile for pregnant people, and making sure Shanice has access to appropriate combination of medication and therapy to treat her SUD, major depressive disorder and schizoaffective disorder. Shanice's BH and SUD planning process, which includes input from the assessments, UnitedHealthcare care coordinator, COMCARE case manager, Providers and Shanice, contains the following interventions:

- SUD treatment with buprenorphine – Ongoing
- Medication management and adherence – Monthly medication adherence check-ins that include Shanice, the CMHC/CCBHC's psychiatrist and her OB/GYN to address efficacy and safety of medication regimen used to treat co-occurring conditions
- Individual therapy – Weekly
- Psychosocial rehabilitation – Weekly
- CMHC/CCBHC case manager touchpoint – Weekly
- Crisis services – As needed

The resulting plan of service is shared with Shanice's care team and Shanice. In addition, the details of Shanice's plan of service are updated in CommunityCare.

Deliver Ongoing, Integrated Care

After the CMHC/CCBHC visit, the HFS RN meets with Shanice at the Oxford House and proceeds to address her pregnancy needs. Given Shanice's substance use and BH needs, she is stratified as having a high-risk pregnancy. By providing Shanice with comprehensive, coordinated care, we can decrease the risk of a NICU admission for the infant due to her SUD/OUD and address the challenges expected during the baby's possible opiate withdrawal. The HFS RN explains the HFS program, including how we can help connect her and her infant to

services (e.g., scheduling prenatal, postpartum and infant well-child visits and connecting her to community resources such as WIC), provide education on benefits, nutrition, breastfeeding and baby care, and collaborate with her OB/GYN. The HFS RN works in collaboration with Shanice to develop an integrated plan of service that includes her pregnancy, birth, BH, substance use and SDOH goals and service needs, in collaboration with Shanice and with additional support by the BH care coordinator and the CMHC/CCBHC.

The HFS RN introduces the concept of a doula to Shanice, explaining doulas provide social, physical and emotional support throughout the pregnancy, birth and postpartum. Doula services support vulnerable communities by providing support other trained professionals may overlook. Shanice is appreciative of the additional support she can receive and agrees to meet with a doula. Nationally, UnitedHealthcare Members working with doulas are 5.4% and 4.3% less likely to have a C-section and a low birthweight baby, respectively.

Next, they review the *Provider Directory*, and Shanice selects an OB/GYN close to the Oxford House. Together, they call and set up her first appointment for the following week, along with [redacted] Next, the HFS RN tells Shanice about the Babyscripts My Journey app and shows her how to use it. Through Babyscripts, Shanice can receive educational information and tips that align to her gestation period and receive appointment reminders to make sure she does not miss prenatal care visits. In addition, through the app, she has access to up to $75 in healthy living rewards gift cards from Walmart that she earns by making and keeping her prenatal care appointments.

The HFS RN shares the multiple community-based programs and resources that support families in Sedgwick County, such as the Sedgwick County Baby Talk classes taught by Wichita Black Nurses Association (WBNA), which provides education on prenatal care, nutrition, stress, things to avoid during pregnancy, labor and birth, postpartum care and newborn care, breastfeeding, safe sleep and other newborn safety and early childhood development topics. They share information as the Kansas Birth Justice Society, a community of health and wellness designed specifically for mothers of color that hosts parenting circles — general, postpartum, breastfeeding and pregnancy circles — with pregnant individuals of similar due dates. The HFS RN tells Shanice that through participation in these programs she can obtain a car seat, baby crib and diapers. Shanice is excited about the resources and shares that she is considering participating in the programs and attending the classes. The HFS RN schedules the next face-to-face check-in visit for two weeks later but encourages Shanice to outreach sooner if her needs change or if she has any questions. They agree that, in addition to the enabled Babyscripts appointment reminders, the HFS RN will send a text message reminder.

The HFS RN stays in close communication with the CMHC/CCBHC and is pleased that Shanice is adhering to her treatment plan. When doing the telephone check-in after Shanice's first prenatal visit, the HFS RN learned that Shanice was 16 weeks (about three and a half months) pregnant. At a subsequent in-person visit, the HFS RN completes the HFS 2nd Trimester Assessment and a PHQ-9. The HFS RN shares with Shanice that she can access a Nutrition Support for High-Risk Pregnancy VAB that provides $145 per month to purchase healthy food items from a designated local vendor for at-home delivery, available in the last trimester and first month postpartum and coordinated through the HFS RN care coordinator. She can receive this benefit in addition to her SNAP and WIC benefits, further supplementing her dietary needs with

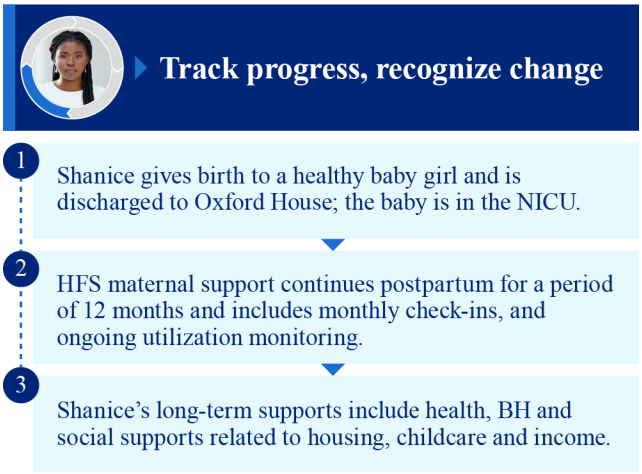
healthy foods to help her and the baby progress. Shanice agrees this is helpful after she transitions from the Oxford House to longer-term housing.

For the remainder of Shanice's pregnancy, the HFS RN provides resources to empower her self-management and adherence. Shanice shares with her HFS RN that she has met with her doula to discuss her preferences and expectations of childbirth and discuss strategies to make the experience more comfortable, which helps calm her nerves. In addition, Shanice advises that she has been attending the Baby Talks classes and connected with the Kansas Birth Justice Society, as such, she already has a baby car seat and crib at the Oxford House and is pending receipt of remaining rewards to purchase additional baby items. The HFS RN congratulates her on the accomplishment and finishes the interaction by discussing benefits of breastfeeding for Shanice and the infant, including infant bonding benefits.

As she nears her due date, Shanice's HFS RN and doula help her develop a birth plan, which she discusses with her OB/GYN before delivery and talks with a pediatrician about establishing care for her newborn. The birth plan indicates Shanice's wishes to have her doula with her during delivery and to begin breastfeeding her baby as soon as possible. The HFS RN helps Shanice order a breast pump and encourages her to discuss birth spacing and family planning options with her OB/GYN. After discussing with her OB/GYN and taking some time to think about her options, she decides to have a long-acting reversible contraception inserted immediately after she delivers. Shanice shares that she has begun reconnecting with her sister. They have been getting together for breakfast once per week and are starting to rebuild their relationship. Shanice is thankful to have her support.

Track Progress, Recognize Change

After a strong last trimester of pregnancy, Shanice is admitted to one of the local hospitals to deliver her baby. She delivers a healthy, full-term baby girl. Her baby is transferred to the NICU, per SUD protocol, to be monitored for NAS since Shanice was receiving buprenorphine during the pregnancy. Shanice is discharged to the Oxford House two days after the delivery, and her baby girl remains in the NICU for an additional five days.



Two days after discharge, the HFS RN and Shanice connect. Shanice is excited to share that her sister came to see her and the baby while in the hospital. She is feeling good about their relationship and is hopeful that she may be able to move back in with her sister and that she will be a support for her and the baby. Shanice is breastfeeding, with the assistance of the lactation consultant arranged by the doula and has been staying at the NICU each day to breastfeed the baby. Shanice adds that she plans to use her remaining reward dollars to purchase baby diapers.

The HFS RN stays in monthly communication with Shanice to check on her and the baby's well-being. Using a family-centered approach that includes education and support, the HFS RN provides care coordination for both Shanice and her baby. The HFS services and supports

continue for 12 months postpartum, where the HFS RN maintains in close communication with the CMHC/CCBHC and follows Shanice and the baby through the natural progression of care and services as follows:

- Review of post-birth warning signs, safe sleep and other postpartum guidance, followed by a review of preventive health care for both Shanice and her baby, with emphasis on recommended preventive screening, and vaccinations
- HFS RN monitors for gaps in her medication treatment for her BH and SUD
- Return to work discussion that includes a referral to the Crisis Nursery in Sedgwick, an organization providing temporary childcare services for families experiencing stressful life situations and can provide a reliable childcare solution for Shanice when she is ready to return to work
- Referral to the Working Healthy Benefits Specialist to understand her options for seeking employment and maintaining her Social Security Disability Insurance (SSDI)
- Referral to VAB supports that include a $200 benefit to apply toward vocational training to allow Shanice to earn an income and provide for her child's needs

Shanice and her sister have restored their relationship, and Shanice and her baby move in with her sister. As long as Shanice remains sober and continues with her BH treatment through the CMHC/CCBHC, her sister is supportive of allowing them to stay with her and provide support. As a single mom with limited income, Shanice is appreciative of the support her sister provides. Shanice is encouraged to contact the HFS RN for help with housing if needs or conditions change. In between monthly interactions, the HFS RN continues to monitor Shanice's utilization and claims records to assess risks or barriers to remaining adherent with treatment and medications. At the conclusion of the 12-month postpartum period, the HFS RN congratulates Shanice on her progress and encourages her to continue services with the CMHC/CCBHC. Shanice is reminded of how to contact the RN or UnitedHealthcare member services if she feels like she needs additional support in the future.

"In the 22 years I have been in this position, I've never experienced such excellent services being provided by a Kansas Medicaid managed care program. The nurse case managers at UnitedHealthcare from the Healthy First Steps Program, have gone above and beyond to advocate, support and provide resources/services to so many of our families. We hope to continue to have this outstanding partnership with United Healthcare in the future."

– Children's Mercy Hospital Kansas

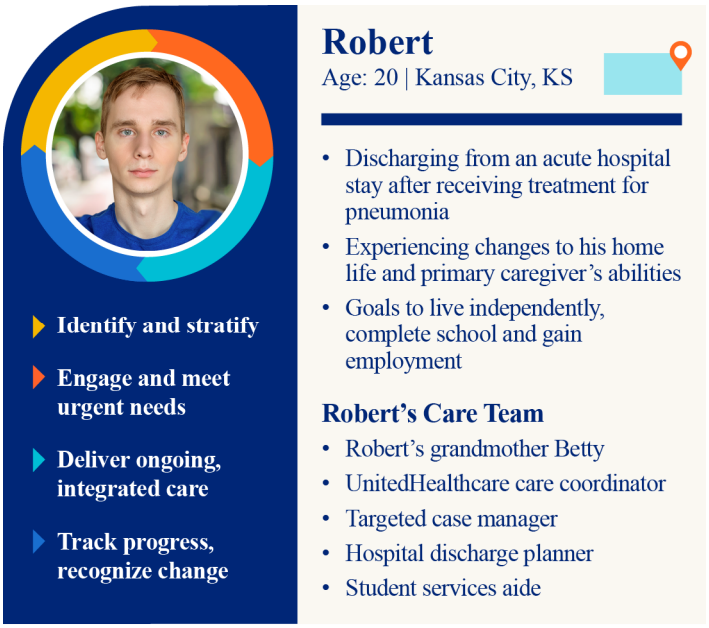
Case Scenarios

29. Robert is a twenty-five (25)-year-old, white, male KanCare Member with Cerebral Palsy enrolled in the IDD HCBS Waiver. He is currently being treated in an acute care hospital for an upper respiratory infection and is nearing discharge. In addition to having a limited ability to meet his basic personal care needs, Robert is wheelchair dependent and requires an augmentative communication device. Robert is currently living with his grandmother, Betty, who has been providing the majority of support for his personal care needs.

Betty recently learned that she has stage 4 rectal cancer and is gravely concerned about her ability to continue to care for Robert when he is discharged, and anxious about who will take care of him when she dies. There are no additional family supports for Robert.

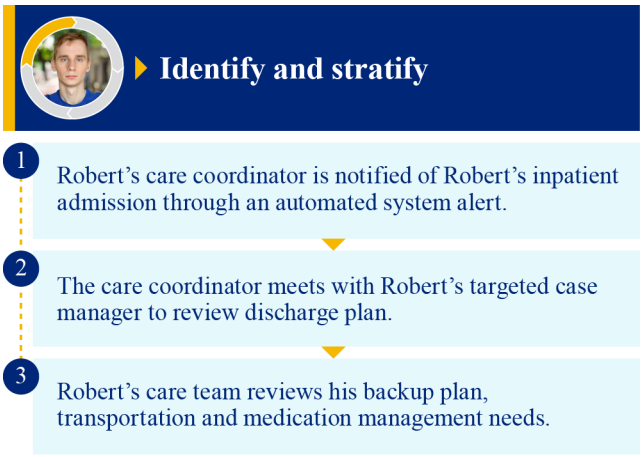
Robert is very intelligent and close to getting a bachelor's degree in computer programming. He would like to live independently, complete his schooling, and obtain employment.

Describe the bidder's approach to supporting the hospital discharge planning process and to initiating and managing Robert's follow-up care to assist him in meeting his short- and long-term needs and personal goals upon discharge.



Robert's case is not just about Robert, his needs and personal goals, but also about making sure Betty has the comfort of knowing Robert is receiving the services and supports he needs to thrive as she focuses on her health journey. Our compassionate team approaches this case using person and family-centered care coordination to provide clear communication, timely access to necessary services, continuity of care and effectiveness of services. UnitedHealthcare has infused our care management team with clinicians and non-clinicians, such as Community Health Workers (CHWs), who have experience supporting Medicaid, home- and community-based services (HCBS), IDD, behavioral health, housing and other social support programs. Our HCBS care coordination teams are waiver specific. Upon enrollment, waiver Members are assigned their specific team geographically according to their waiver; the care coordinator, manager and program manager are experienced in the nuance of this waiver and work to support Member satisfaction. **Our 2023 Member Satisfaction Survey showed Members enrolled in an HCBS waiver reported a 97% satisfaction rate with their UnitedHealthcare care coordinator and a 96.9% satisfaction rate with their HCBS.** We use integrated care coordination solutions, processes and tools that support our whole-person care model. **In UnitedHealthcare's 2023 State Audit, our backup planning for Members enrolled in the HCBS waiver was identified as a strength of our care coordination program.**

Identify and Stratify



Robert is engaged in our HCBS care coordination program and has an assigned care coordinator, who communicates with Robert and his care team regularly. An automated alert generated by an admission, discharge and transfer in our care management system notifies his care team of Robert's inpatient admission. Robert and Betty, Robert's grandmother, have a well-established relationship with the care coordinator and know they can contact them any time with questions, concerns or to notify of changes in health status. Betty contacts the care coordinator to talk about Robert's needs upon discharge and her concerns with remaining his primary caregiver. The care coordinator reaches out to the hospital discharge planner to provide contact information and support the development of a successful discharge plan with minimal disruption and continuity of current Provider(s), when possible. The care coordinator requests a copy of the discharge plan when available.

Through review of the inpatient authorization and after speaking with the facility's discharge planner, we learn Robert has been diagnosed with pneumonia. He is finishing his intravenous antibiotics and will be transitioned to oral antibiotics before discharge. He will continue to use inhalers following discharge. Robert will complete education with the hospital's respiratory therapy team before discharge to make sure he is using them effectively.

Following initial contact with the discharge planner, the care coordinator contacts Robert's TCM Provider to make sure she is aware of the hospital admit and confirm there is not duplication of coordination activities. The TCM and care coordinator work as a team to focus on opportunities for integrating care and services, improving independence and self-determination and making sure Robert can live and work in his community. Robert has been working with the same TCM for several years and has been with them before coming to UnitedHealthcare; they are seen as a vital part of his support team. The TCM has connected Robert with community resources that have been beneficial over the years. The care coordinator shares Robert's diagnosis with the TCM, recommendations for treatment and anticipated discharge date. The TCM and care coordinator discuss the possible changes that will need to be made to Robert's plan of care via both the person-centered support plan and the person-centered service plan due to the changes in Robert's condition and support team. The TCM indicated they would follow up with Robert and inquire if the person-centered support plan addendum meeting can be held at the same time the care coordinator will be completing the face-to-face visit post-discharge. This way the care coordinator, the TCM, Robert and his support team can collaborate and make sure that efforts to help Robert are not duplicated. The care coordinator reviews the person-centered service plan to identify Robert's HCBS Providers reaches out to notify them that Robert is in the hospital and will not be needing his HCBS for a short time.

Throughout the hospitalization, the care coordinator maintains ongoing communication with the hospital discharge planner to stay current on his care plan and discharge expectations. In

addition, the care coordinator works with other members of Robert's interdisciplinary team (IDT), including his TCM, to verify services and supports are arranged and schedule his HCBS to begin the day he discharges to home.

When Robert is ready for discharge, Robert, his care coordinator and TCM Betty, discharge planner and other IDT care team members, meet to review Robert's discharge plan. The facility has assisted Robert with scheduling a follow-up with his PCP. The care coordinator coordinates with Robert and the PCP to remove any barriers to keeping this appointment, such as transportation and any support needed during the appointment. Betty confirms that she will be home and available to help Robert once he has returned home. The care coordinator reviews the backup plan that is already in place with Robert and Betty in case Betty is not feeling well and is unavailable. Robert and Betty have previously identified and confirmed that their neighbor is available to step in to help on an as needed or per diem basis, with additional backups identified as a few of Robert's friends, but Robert would need an alternative permanent caregiver when Betty is unable to help. Due to his limited mobility and new pneumonia diagnosis, an incentive spirometer is ordered to make sure that he is filling his lungs fully with deep breaths to prevent secondary pneumonia. Robert has been trained by respiratory therapy on how to use his inhalers and incentive spirometer. Robert's care coordinator notes that home health for medication management immediately following discharge would be beneficial to his discharge, so the care coordinator confirm home health services have been arranged with a network Provider before Robert's discharge.

The next day, the hospital discharge planner communicates to the care coordinator Robert's discharge. Robert's care coordinator also receives notification through a discharge alert in CommunityCare, our integrated care management system, which alerts the care coordinator to complete the post-hospital assessment (PHA). In addition, our blended census report tool, which contains details on hospital admit and discharge, is sent daily to our care coordination managers and distributed to the care coordination teams for timely follow-up on discharge planning activities and PHA. The care coordinator will outreach Robert to complete the PHA within 48 hours of discharge.

Engage and Meet Urgent Needs

Once Robert has returned home, his care coordinator contacts him by text using his Lightwriter adaptive technology previously obtained through Assistive Services on the IDD waiver at recommendation from speech language pathologist. This allows Robert to provide information directly to complete his PHA, which includes:

- The reason or cause of the inpatient stay (e.g., transportation, access to care, self-care issue, change or worsening condition, medical issue, accident, clinical issue)
- Robert's discharge instructions and whether he and Betty understand them or have any questions

- Medication review to determine changes in medications, medication adherence and barriers to medication adherence
- Whether Robert's doctor order new services. If so, have they started? Issues?
- Whether Robert has already completed follow-up with PCP or has an appointment scheduled
- Determining any barriers to getting to appointments
- Awareness of signs and symptoms to watch for that might indicate a worsening of condition and education on a variety of topics and action plan
- Discussion with Robert on how he can be a support to Betty regarding her new cancer diagnosis, along with how he is personally managing this change from a behavioral health perspective
- Review of advance directives and how to access NurseLine, available 24 hours a day, seven days a week

Supporting Members through Adaptive Technology

Through Assisted Services on the IDD waiver and at the recommendation from a speech language pathologist, Robert receives a Lightwriter adaptive communication device. The device is small, lightweight and easy to transport, and the dual screen enables the user to type the message while the listener is sitting in a natural position for easy dialogue. It also includes a text-to-speech feature when communicating with others in the room. We also love the SIM card feature, which allows users to send text messages to friends and family. Additional features of the Lightwriter include a notebook feature, built-in buzzers to summon attention, alarms to remind the user of important events and a built-in remote control for the television.

Following the completion of the PHA, Robert and his care coordinator agree that an in-person visit is necessary to better discuss his care needs and the worsening health of his primary caregiver. The care coordinator schedules the visit based on Robert's preferred time and coordinates with his TCM to attend the visit as well.

During the in-person visit, the care coordinator completes the needs assessment to review any changes in Robert's activities of daily living (ADLs) and instrumental activities of daily living (IADLs) needs since his discharge and change in caregiver support. Robert denies needing any additional support with ADLs; however, despite his denial, the care coordinator assesses additional weakness after being hospitalized. Robert has indicated generalized weakness when doing tasks that were previously relatively easy for him to complete. For example, Robert described that he had difficulty in repositioning himself in his wheelchair, dressing himself and participating in transfers to and from bed. The care coordinator informs Robert that physical and occupational therapies may be beneficial to help him regain strength, evaluate for any possible durable medical equipment or minor home modifications, assistive technology or assistive services needs that have not yet been identified to help him be more independent. Robert agrees to participate in a physical and occupational therapy evaluation. The care coordinator coordinates with Robert's PCP to establish physical and occupational therapy orders to evaluate and treat with the existing home health agency. Due to Betty's recent cancer diagnosis, Robert will need additional IADL support that Betty had been providing informally. The care coordinator suggests adding paid personal care time for Robert's portion of cleaning, laundry, shopping, meal prep, medication administration and assistance with medical appointments or community inclusion activities. This would include time for shopping, which Robert says he wishes to participate in to improve this life skill.

As discussions continue with Robert and his grandmother, his most urgent need is identifying another caregiver to help with his personal care needs to be prepared for when Betty is unable to continue acting as a caregiver. Robert expresses concern and some anxiety to the care coordinator about the uncertainty during this transitional phase. His grandma has been his primary caregiver for much of his life. He is concerned about his grandmother's health and about securing a new caregiver that is as compassionate, caring and familiar with augmentative communication as his grandmother. Through discussion of other natural support and existing community connections with the care coordinator and TCM, they determine that his existing student services aide will assist Robert with posting requests for a caregiver on the school's online message board system. Robert and his care coordinator review the online personal care directory, Rewarding Work, to search for an appropriate caregiver. The care coordinator shares that upon returning to the office, she will complete an internal Provider search referral, which assigns a CHW to complete outreach to all network Providers. Given that Robert's caregiver needs are urgent, the care coordinator also outreaches via phone and email to local Providers in search of an available caregiver to meet Robert's preferences and caregiving needs, while maintaining HIPAA regulations. Robert's neighbor is his backup plan support for his ADL and IADL needs and can provide support immediately, until another long-term caregiver is found and can complete necessary paperwork to apply as a self-directed caregiver.

The care coordinator reviews and updates the person-centered service plan with the additional service hours Robert will receive. Robert wishes to keep Betty as the first contact; however, if she is unavailable, the backup plan will be activated. Robert agrees and signs the plan.

While in the home, the care coordinator confirms Robert's follow-up appointment with his PCP, scheduled before his discharge, to ensure his awareness and intention to keep the appointment. With his grandmother's new health issues, Robert requires transportation assistance to attend his appointment. Robert and his care coordinator identified his neighbor, acting as his backup caregiver, can attend the appointment with him and arrange for nonemergent medical transportation, verifying wheelchair accessible transportation will be provided for all of Robert's trips. The care coordinator asks if Robert has been contacted by the home health agency, and Robert responds that they will be making a home visit the next day to begin his respiratory therapy and medication management to help him feel more comfortable with his new prescriptions and support his use of an incentive spirometer. His neighbor can be present for the home health visit. The care coordinator confirms with Robert each medication he is taking and updates the integrated care management system with his new prescriptions and enters the discontinuation date for any medications he is no longer taking.

Supporting Caregivers

Careforth is a market leader in the caregiver space with solutions that focus on engaging, empowering, educating and supporting caregivers. Caregivers are assigned a coach who provides education on caregiving topics through an approved curriculum and is available to discuss caregiving concerns unique to the caregiver. The program's goals are to increase active engagement in the Member's care team, increase caregiver confidence and reduce caregiver burnout.

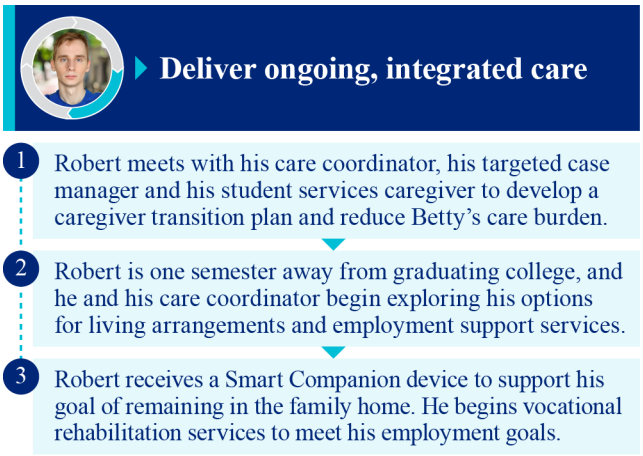
Knowing the uncertainty of Betty's condition and the expressed anxiety Robert and Betty have already shared, the care coordinator presents options for mental health therapy support. The in-home family counseling associates offer in-home mental health visits. Robert agrees that home visits would be best for him as he would not have to worry about transportation or caregiver barriers to access the care. Betty and Robert set a goal to participate in family therapy once Betty's health is stable and their schedules permit. The care

coordinator explains the resources available to Betty as Robert's caregiver, including our partnership with Careforth, a benefit available through UnitedHealthcare. The Careforth Caregiver Program identifies informal caregiver supports and offers a coaching program, which includes tools, education, virtual support and a dedicated outlet for Betty to discuss her caregiving journey and evolving needs given the changes in her health.

While meeting with Robert and Betty, the care coordinator hears the concerns regarding Betty's care as her treatment and cancer progresses. The care coordinator provides her with contact information to the Area Agency on Aging, who can help assess Betty for qualifying services, like home-delivered meals and Senior Care Act, which may provide services, including attendant care, respite care, homemaker services and chore services, on a sliding fee scale.

Through motivational interviewing techniques like reflective listening, the care coordinator better understands Robert's personal goals of completing his education, living independently and gaining employment. To help Robert work toward his goal of living independently, his care coordinator schedules a second face-to-face home visit for reassessment, which is focused on assessing the supports and services Robert would need to live safely and independently. Robert indicates he would like his TCM to attend the second visit as well.

Deliver Ongoing, Integrated Care



Robert, his care coordinator, his TCM and his aide from student services meet to discuss different options for Robert's transition plan. Robert shares that Betty has been mostly unavailable due to her condition; however, they remain optimistic and hopeful. Robert has recently finished his antibiotics and home health completed their last visit this week. The care coordinator spoke to the nurse at the PCP's office, who confirmed that Robert has been cleared to resume with normal checkups. Through assistance of Robert's care coordinator and the TCM, a caregiver is found to provide Robert's personal care services. Robert's new caregiver will provide support at home with the neighbor remaining as the backup caregiver.

Robert and his student services aide share that he is just one semester away from graduation. Knowing that Robert's goals are to live independently and obtain employment, the team discusses all three living possibilities available so Robert can make a fully informed decision:

1. **Remaining in Family Home:** Robert would remain in his home with Betty as caregiver support. Betty currently owns the home, but the home will become Robert's upon her passing, so he would be responsible for the property taxes, insurance, upkeep and utilities.
2. **Group Living Residential Services:** Residential services in a group setting.
3. **Independent Living Residential Services:** Robert could get his own apartment to receive services and live independently.

When discussing residential services options, Robert states that he does not prefer to live in a group setting because he is working on a degree that will likely lead to employment; however,

Robert still wants to tour residential Providers so he can make an informed decision that will best fit his needs. Robert is excited about graduation and starting his career. He says this would help increase his independence and give him a sense of purpose. He shares some concern about how his earned income might affect his current KanCare benefits. He understands that if his income rises over the state threshold, he might not be able to keep his medical and waiver benefits. The care coordinator explains the Working Healthy/WORK program to Robert, which could provide him ongoing supports in his home and allow him to keep his benefits, while earning a higher income. The care coordinator talks with Robert about reaching out to Kansas Department of Health and Environment's Working Healthy benefits specialists to participate in benefits counseling. Robert can work with his specialist to make sure he understands how any earned income can affect his benefits and when it may be beneficial to enroll in the Working Healthy/WORK program.

After exploring his options and touring residential Providers, Robert decides he wants to remain in his family home. In discussing living options, Robert's care coordinator identified Smart Companion as another way to support his goal of safely living independently. The care coordinator and Robert discuss the benefits and how the device operates, including that Smart Companion will work with his existing communication device and recognize his voice commands. Smart Companion has a dedicated internet router, an Amazon Echo Show, Amazon Alexa Dot and Amazon Alexa Globe. The Dot device is plugged into the bathroom for Robert to use as a personal emergency response system. Robert can say, "Alexa, call for help," which will alert a call center to triage the call for help and dispatch assistance, if necessary. The Globe is installed in his bedroom and is activated in a similar manner. The Echo Show is installed in a common area in the home. In addition to the emergency call function, the devices can call up to five individuals of Robert's choosing. Robert can call his backup caregiver, family member or TCM. The devices include brain games and weather updates so Robert can dress appropriately; Robert can use the timer and alarm functions when he is cooking or to help organize his daily schedules and medication times. Robert can also use the devices in a way similar to home intercom systems to broadcast to one another through the "Alexa, broadcast" command to connect to the other devices inside the home to call for help if another person is present, but not in his immediate vicinity. Robert's contacts can communicate without need for a device by downloading the Alexa app, through which they can participate in video visits or calling Robert through his device number.

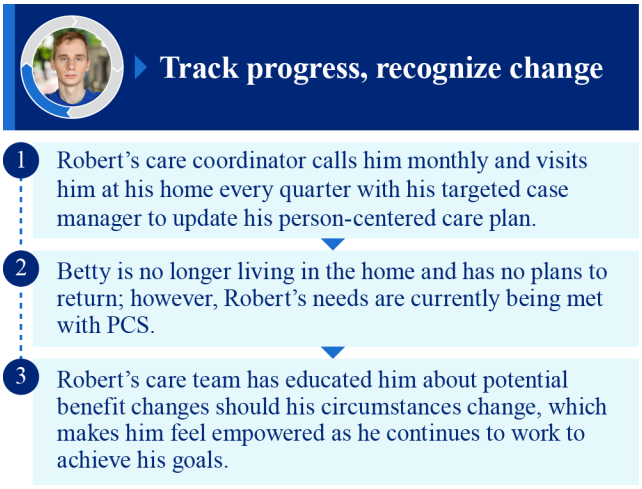
Robert is eligible to receive vocational rehabilitation (VR) services, specifically designed to help Kansans like Robert meet their employment goals. His student services aide helped him apply to VR in preparation for graduation and entrance into the workforce. The VR services Robert will receive are customized to his unique needs, skills, interests and abilities. Robert can be provided a vocational assessment to help identify skills and job goals, vocational counseling and guidance, training and education, job placement services and supported employment. Through VR services, Robert would be able to access professional counselors, who have expertise in helping people with disabilities achieve employment and addressing the barriers Robert may face. The VR counselors will help him develop a plan to identify the type of job he wishes to have, the services he will need, his rights and responsibilities related to his employment.

Robert can receive day supports in connection with vocational rehabilitative services. Day Supports offers various programs that can support his needs, many of which are focused on promoting job skills. Robert can attend Day Support part time while working to complete his

degree, allowing him opportunities to learn, practice job skills and provide socialization opportunities. Robert agrees that the program would be beneficial to him, meet his needs and help him work toward his goals during times when he is not in school or at home. His care coordinator helps Robert to plan for transportation when needed.

After these discussions, Robert's TCM plans to update Robert's person-centered support plan, which outlines his care needs and personal goals, including his preferred lifestyle. The care coordinator coordinates a formal transition plan with Robert, his TCM, his current personal care services (PCS) Providers, his day supports and fiscal management services (FMS) Providers.

Track Progress and Recognize Change



Robert's care coordinator contacts him monthly by telephone and visits him at home every quarter with the TCM. During these meetings, Robert shares any changes in condition, progress toward his personal goals and any issues he needs help with. The care coordinator and TCM will continue to monitor his progress and are prepared to provide support to maintain Robert's ability to live safely at home.

While still in school, Robert begins day supports with VR partnership while continuing with his PCS supports at home. Robert selects a Day Supports Provider that can support his employment goals and work in conjunction with VR. After graduation, his grandmother's health deteriorates. She is no longer living in the home and there are no plans for her to return. As it is the only home that Robert has known and is set up to meet his needs, he wishes to stay. Through our regular assessments and collaboration with his TCM through the person-centered support plan, we review his needs, the appropriateness of his care plan and any staffing changes Robert may need. Robert knows that if PCS no longer meets his needs at home, he can access residential supports in his own home. Before Betty's condition worsened, she and Robert confirmed the legal and financial aspects of the transfer of the home from Betty to Robert was completed and that an advance directive is on file with the care team and PCP. Robert will continue job training with VR and transition to the WORK program when he is ready.

Robert understands that, when moving from the IDD waiver to the WORK program, he will no longer have access to a TCM and his IDD care coordinator will transition to a UnitedHealthcare WORK care coordinator. Upon transition to the WORK program, the WORK care coordinator will provide Robert with their choice of independent living counselor (ILC) and will assist with establishing that initial relationship. Robert's ILC would be authorized for 120 hours per year for assistance and support services.

The WORK care coordinator will complete an initial WORK Assessment in the Member's home and invites the ILC to attend. The ILC will assist Robert with establishing their initial WORK Budget. The ILC is responsible for assisting Robert with the use of his monthly allocation and assisting to revise the budget when changes are necessary. The ILC helps educate Robert on FMS and Personal Care Aid timesheet verification. ILCs are responsible for making sure

Members fully understand their rights and responsibilities as outlined in their WORK Agreement. The ILC will assist Robert to complete his emergency backup plan to outline plans during a natural disaster, emergency physician assistant care and emergency pet plans. The WORK care coordinator is responsible for reviewing and approving the budget to make sure the supports identified during assessment are included. Once the initial budget is implemented the WORK care coordinator completes through points with Robert quarterly. Both the WORK care coordinator and ILC meet with Robert at least twice a year in his home and contact Robert at least twice by phone each year. The ILC will provide Robert with ongoing support and guidance with choices regarding their WORK Services and ongoing paperwork. In collaboration with the ILC, the WORK care coordinator assesses for needed community resources and completes necessary referrals. If Robert has any questions regarding his health care benefits and/or coverage his WORK care coordinator is available to assist.

If Robert becomes steadily employed and his income rises above the KanCare limit, then Working Healthy/WORK would benefit him. If his income remains at a level that does not require a client obligation, then it may be more beneficial for him to remain on the IDD waiver. Ongoing contact with the Working Healthy benefits specialist will assist him so he is educated about how his income can affect his benefits eligibility. His IDD care coordinator will continue to talk with him monthly and visit with him in person at least quarterly to monitor progress toward his personal health and wellness goals.

Helping a Member Like Robert: Dustin's Story

Dustin is 24 years old with cerebral palsy and relies on his powered chair for mobility. He is enrolled in the IDD HCBS waiver and has worked with the same UnitedHealthcare care coordinator for years. He currently lives with his grandmother, Sheila. While his needs are currently met, his grandmother is getting older and having trouble caring for Dustin. As Dustin has aged, he desired more privacy and a male caregiver to help him at home. His care coordinator helped him find a male caregiver, Darien, through community connections.

Dustin can communicate his needs verbally and he has his own cellphone and email address. Previously, his mother served as his guardian, but Dustin expressed a desire to become his own guardian. His care coordinator encouraged him to advocate to become his own guardian. The judge agreed that he had capacity to make his own medical and financial decisions. For support organizing his finances, Dustin designated his grandfather, James, as his payee.

Dustin wishes to live more independently, have more privacy and live among his peers. Dustin is currently touring IDD residential homes in Shawnee County, with his care coordinator's help. Dustin is working toward his bachelor's degree in computer programming. On weekdays, he attends day services at TARC, an organization which supports individuals living with intellectual and developmental disabilities, and he hopes to continue his personal growth and work toward achieving his goals.

Case Scenarios

30. Billy is a thirty (30)-year-old, white, male KanCare Member currently residing in a skilled nursing facility (NF) as a result of injuries sustained in an automobile accident, including a traumatic brain injury. Billy has been living in the skilled NF for the last 14 months. Billy receives physical and speech therapies but continues to struggle with slurred speech, coordination, and balance. He is eager to move back into his home, eventually go back to work, and "get his life back".

Billy recognizes that he may still need assistance in order to manage basic needs in his home, but finds being in a "nursing home" is depressing and lonely. In addition to his physical and speech challenges, Billy is overweight and developed a stage 3 pressure ulcer. He also experiences periodic incontinence.

Describe how the bidder will assist Billy in planning for and implementing Billy's transition, including monitoring.

We have a systematic approach to identifying Members who can successfully transition from nursing facility (NF) to community and provide person-centered care management and support planning to support their long-term success in the community. **We successfully transitioned 451 Members from the NF to home- and community-based services (HCBS)** from 2019 to 2022, with an additional 139 transitions anticipated by 2023 year-end. Of those Members we have transitioned, **100% remained in their communities for 90 days, and 98% remained in their communities at least 120 days.**

We will support Billy's goals of improving his well-being and independence, including his desire to transition back home, through our person-centered care model. This approach uses high-touch, in-person and telephonic care coordination to help Billy achieve his lifestyle goals. Billy, his family and his NF can contact his assigned care coordinator to navigate through any challenges related to the availability and access to necessary benefits and services. Throughout his health care journey, the UnitedHealthcare care coordinator will work with Billy to coordinate services.

Identify and Stratify

During Billy's annual health risk assessment (HRA) completed at the NF by his assigned care coordinator, he shares his strong desire to return home and live independently in the community where he has lived for most of his life. Billy misses having more privacy, watching his favorite sports teams and building model cars. Billy's family, who live in a neighboring town, are supportive of his goal to return home. To determine if Billy can transition back to his home

safely, the care coordinator stratifies him into a Level II/III risk level and engages a transition specialist who specializes in the complexities involved in transitions and will provide him dedicated support for his transition. In collaboration with the care coordinator, the transition specialist meets at the facility to better understand Billy's current needs and treatments he receives through discussions with the NF, Providers, including speech and physical therapists, and nursing staff. This discussion allows for a better understanding of his current needs and identifies needed services and supports for a safe transition home.

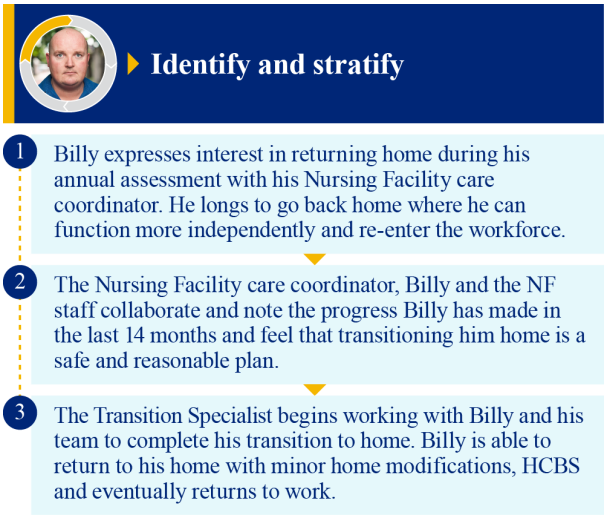
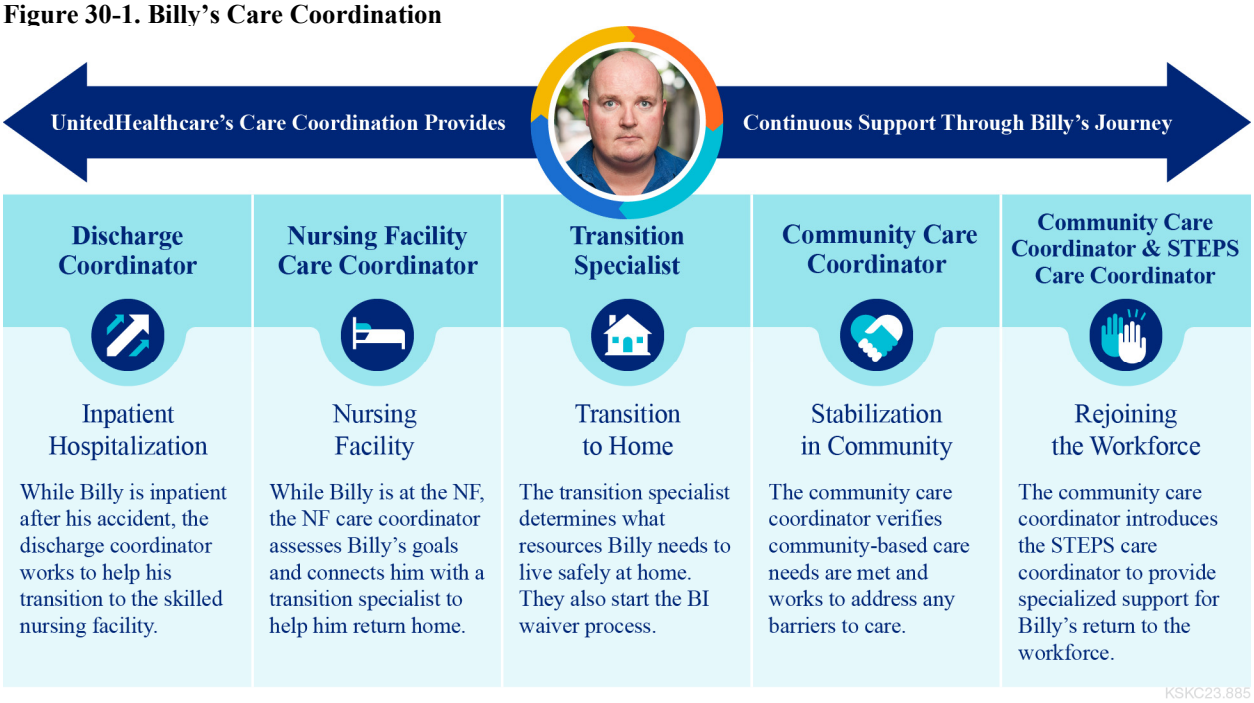


Figure 30-1. Billy's Care Coordination



Billy confirms that he has secured social security income since his accident. They discuss housing and Billy shared that while he has not been home since his motor vehicle accident, he does own the home, as it was previously owned by his late grandparents. The transition specialist notes that the home will need to be assessed for safety and any necessary modifications to accommodate him before discharge. Billy shares his utilities have been shut off since he has been hospitalized for a significant period of time and had an unknown discharge date. He indicates to the transition specialist that he owes approximately $400 in past due utility bills before his utilities can be reconnected. Billy's transition specialist lets him know they can identify resources to help with the past due amount and helping him apply for Low Income Energy Assistance Program (LIEAP) or utility assistance moving forward.

Using PointClickCare to review NF records, the transition specialist collaborates with care coordinator, Billy and his family to complete the following assessments:

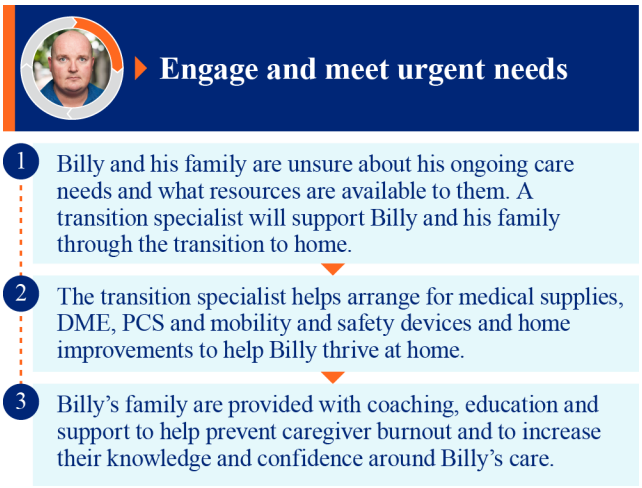
Assessments Completed During Planning Visits	
Assessment	**Purpose**
Adult Health Risk Assessment	Provides a longitudinal comprehensive assessment of Billy's past and current physical and behavioral health conditions and experiences.
Functional Needs Assessment (FA)	Identifies the areas where Billy will need the assistance of caregivers to be successful at safely meeting his needs while residing independently in the community. The FA will help the transition specialist determine how many hours and the services needed to support Billy in his home.
Participant Interest Inventory	Billy fills out the inventory to specify his strengths, goals and desires for the future. In the inventory, Billy expressed his long-term goal to return to the workforce.
Brain Injury Screening Tool	We developed a screening tool that helps specifically identify the types of therapies that would be most beneficial for Members transitioning with a brain injury (BI) such as Billy. The transition specialist is already aware that speech therapy and physical therapy are indicated, although Billy has continued to make progress at the facility. He qualified for cognitive therapy and transitional living services.
Home Evaluation	Assesses the home for safety and informs any home modifications and durable medical equipment (DME) needs.
Community Transition Screening Assessment Tool	Our community transition screening tool identifies potential barriers that will need resolution, supports Members' choice of residential environment such as independent living in the community, assisted living, Homes Plus.
Transition Planning Tool	Our proprietary transition planning tool is intended to identify all areas of transition, including finances, safety concerns, minor home modifications, follow-up for medical and behavioral Providers, barriers needing resolution and DME.
Transition Budget	We have funds that can assist Members to replace or purchase items they may require for a successful transition due to having been in a facility for a significant length of time or a change in their level of function. These things may include furniture, deposits or past due bills and housing goods. The Transition Budget is used to help determine and track UnitedHealthcare funds needed for Member transition to the community.

Billy does not require any hands-on assistance for mobility or transfers in the facility though he will use a walker when needed. His transition specialist will confirm he has a walker available for home use upon discharge. Speech therapy reported that Billy experiences some slurred speech, typically on days or times when he is more tired; however, he is not in need of any type of communication device at this time. He is successfully able to communicate his needs. To

determine if Billy's home is safe and accessible, the transition specialist requests a home evaluation by an occupational therapist.

Billy shared that he has been feeling lonely and experienced some feelings of depression since his accident. He was screened and diagnosed with depression but did not indicate any concerns for self-harm, suicidality or substance use. Billy was prescribed an antidepressant by a BH advanced practice nurse practitioner who routinely visits the NF and receives ongoing medication management through the NF pharmacist. As Billy transitions to the community, the transition specialist will assist him in identifying community-based Providers to support his ongoing medication management needs.

Engage and Meet Urgent Needs



Based on assessments and home evaluation, Billy engages with the team to discuss the recommended supports and services that he will need upon transition to home. Billy and his family are unsure about the ongoing care he will need and resources available to them. The transition specialist explains the transition process and the roles of the care coordinator and the transition specialist. They explain that the transition specialist who will be working with Billy on his transition plan and for his first 45 days home. After his first 45 days home, a care coordinator experienced with working with Members who have a brain injury (BI) will be working him. The transition plan includes the following supports, which are documented in his person-centered service plan:

- **Home Health:** The transition specialist helps Billy identify a home health agency to provide intermittent in-home nursing visits for wound care for his Stage III ulcer.
- **Utilities:** Transition specialist helps Billy apply for LIEAP assistance and connects with the local Salvation Army who can assist Billy with his past due utility bills.
- **Medical Supplies:** To address his periodic incontinence, Billy will have home delivery of incontinence briefs as needed.
- **Therapy Services:** Billy qualifies for the BI waiver and will receive cognitive therapy, speech therapy, behavioral therapy and Transitional Living Supports to relearn life skills such as housekeeping, cooking, money management and community inclusion.
- **Durable Medical Equipment:** The care coordinator arranges for a bariatric bed with a low air loss mattress for wound healing and a walker when needed for coordination and balance. Billy selects a handheld shower as his CMS approved item with his annual UnitedHealthcare over-the-counter $50 VAB.
- **Medical Team:** The transition specialist identifies local network Providers for Billy to choose from to receive primary care services and ongoing management of his BI and depression. Appointments will be set with his selected PCP, neurologist, urologist and speech, occupational and physical therapy closer to his discharge date.

- **Transportation:** Billy will need transportation to his medical appointments, so the transition specialist worked directly with Billy to educate him on the process for accessing nonemergent medical transportation services for future needs and support for all future transportation needs.
- **Personal Care Services:** The transition specialist considers the supports Billy will need to complete daily tasks like meal preparation, traveling to grocery store and maintaining the household. Based on assessment and current care received in the NF, he qualifies for 25 hours of personal care service (PCS) support to complete his activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Billy is educated on the choice to use an agency or self-direct care for PCS. After learning the responsibilities, financial management services and care coordinator role, Billy decides he would prefer to self-direct and receive care from family and/or friends. His long-term girlfriend agrees to be primary caregiver. Together a backup plan is developed where his aunt will be a relief caregiver.
- **Personal Emergency Response System:** A personal emergency response system is provided through LifeLine to detect falls and other accidents and connect Billy to emergency services and alert designated emergency contacts.
- **Care Transition Shopping:** Community transition Members often have experienced significant functional ability changes before their stay in long-term care. We evaluate these needs and make sure Members are provided with new items for safety and security in their successful transition. It is important to include our Members in these choices and meet with them to do this shopping together. Billy was identified as needing several new items to improve his mobility and safety in the home, including a new recliner and a steady table and chairs that he can use to safely stand and transfer after meals. The transition specialist meets with Billy to shop virtually for these items, allowing him to select the items that will be in his home. The new furniture will be delivered before his transition home.
- **Meal Delivery and Cooking Classes:** Billy shares that he used to love cooking and hopes to regain his independence in the kitchen. Billy's care team will work to achieve this goal with the waiver services; the care coordinator offers online KS Healthy Dining classes. To supplement his nutrition while he works to regain independence in the kitchen, the transition specialist offers to arrange for meals to be delivered to his home during the initial transition period. Billy has expressed a desire to lose weight to help his mobility so to support this goal, the transition specialist will choose the low carbohydrate/diabetic option and can assist him in finding a nutritionist to work with.
- **Addressing Social Isolation:** We identified social isolation as a significant quality of life concern for Members particularly on the BI waiver and implemented a program in early 2022 to address feelings of loneliness through our Smart Companion program. The Smart Companion program provides an Amazon Alexa Echo Show device that Members can use to interact with identified family and friends along with accessing games, jokes and weather. Billy shares he is somewhat hesitant meeting new people and would prefer online support groups for now. He reported he was excited about the possibility of the Smart Companion program but is not sure he can afford internet on his current income. The care coordinator shares Billy has a VAB for home internet that will be provided to him.
- **Pharmacy:** The transition specialist assists with connecting Billy with Genoa Healthcare pharmacy who offers mail order medications in an easy-to-use bubble pack. The service is free to UnitedHealthcare Members.

- **Home Modification:** The home evaluation is completed by an occupational therapist, who noted that Billy would benefit from the installation of shower grab bars, the widening of doorways into the bathroom to accommodate Billy's walker when he needs it and the addition of a ramp to the front door, which has three steps which are not stable due to the age of the home. The modifications are scheduled to be complete before his transition home.
- **Backup Caregiver:** Billy's aunt is identified as an alternate caregiver on his backup plan and she agrees to be available when his girlfriend is unavailable.
- **Caregiver Supports:** We are well informed about the reality of caregiver burnout and need for support. As a result, we introduced Careforth, which is a competency-based training program tailored to individuals providing personal care. Caregivers are able to receive support through coaching, education and support to increase knowledge and confidence along with support emotionally to prevent caregiver burnout. Billy's girlfriend and aunt are educated and provided access to Careforth.
- **Transition Support Training:** Billy's girlfriend and aunt shadow his care routine at the NF to observe and participate so they can assist Billy with his care when he returns home.

"We have worked with UnitedHealthcare on more than 175 transitions from facility to home and the collaboration has been greatly appreciated. No other state provides what the brain injury waiver in Kansas provides and UnitedHealthcare fully understands this and does the 'whatever it takes' to make sure that people who often have complex needs get the services and supports they need to live where they want to live. Their person-centered approach and the way they develop positive relationships with Members are key variables to their success."

– Dr. Janet Williams
Minds Matter, LLC

With Billy's urgent needs identified, addressed and safety determined through his transition plan, the transition specialist sends the HCBS Referral and Notification Form (RNF) to the State for Billy's BI waiver approval, as a minimum of 30 days advance notice is required for institutional transitions and brain injury waiver approval per State policy.

Deliver Ongoing, Integrated Care

With his services arranged and home modifications successfully completed, Billy is discharged home 90 days from identification for transition. To support care continuity now that he is living in the community, an in-home visit is arranged for Billy's transition specialist and his community care coordinator who will work together as part of Billy's care team to discuss his history, current plan and goals.

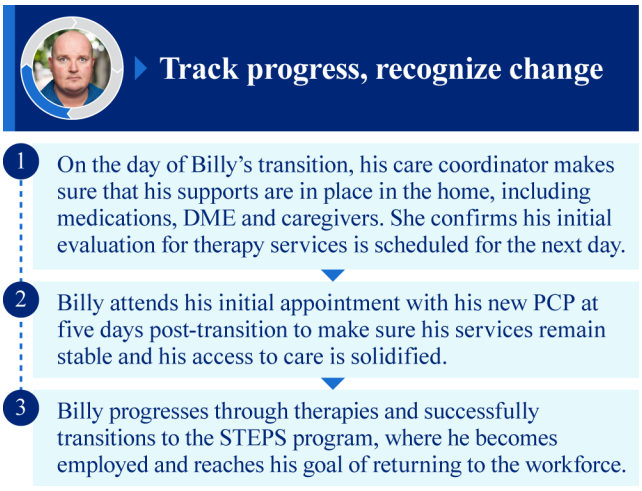
The community care coordinator verifies that Billy's BI therapy services, including speech therapy, occupational therapy, physical therapy, cognitive therapy and behavioral therapy, were coming the next day to conduct their in-home evaluation. Knowing transitions to home can be overwhelming, the care team reinforce that the family is not alone and all are there to support Billy's success. They make sure Billy and his

caregivers know how to reach the team with any questions or concerns. Billy will receive a follow-up call within three business days to check in and see if any new needs have arisen. Billy reports that all services are occurring as planned, and even his low carb meals are satisfying which is part of his plan to reduce his weight.

Billy schedules his transportation through the Transportation Hub to attend his follow-up appointment with his new PCP five days after his discharge from the NF. During his initial visit, he is formally established as a patient and scheduled for future appointments every three months. Billy's PCP monitors him closely during the months following his transition home. The PCP monitors Billy's wounds for continued improvement with the home health wound care team. Billy and his care team is educated on how to schedule future transportation through the Transportation Hub for his upcoming appointments.

Billy's quality of life is more than his physical and behavioral health needs being met. The care coordinator discusses his interests and hobbies. Billy shared he enjoyed building model cars but hasn't built one since his accident. His care coordinator researches ways to bring this hobby back into Billy's life. The care coordinator finds a local group of model car builders who meet weekly in Wichita and several other online enthusiast groups. Billy said he is not quite ready to engage in person but said he would like to look into the online resources and research models, tools and supplies which work well for people living with coordination issues like his. Using Billy's research, the care coordinator was able to use community transition funds to buy a few supplies and a model car kit for Billy to work on.

Track Progress and Recognize Change



During Billy's 30-day follow-up call, his transitional specialist learns that the girlfriend is feeling very overwhelmed and struggling with needing to provide Billy's personal care needs. The transitional specialist connects with the community care coordinator and schedules a face-to-face meeting to meet with Billy and the girlfriend in the home. The team meeting goes well. All parties openly share feelings of being overwhelmed and express their desire to support Billy, but in a less hands-on manner. Due to the change in circumstances, the community care coordinator reminds Billy of his options for self-direct vs. agency-directed services. Billy decides the agency-directed services will best meet his needs at this time. His girlfriend is willing to continue providing his PCS hours until the agency-direct workers are located. Billy's UnitedHealthcare care coordinator and community care coordinator immediately begin working to determine which area agency-direct Providers may be able to serve Billy's needs. A provider is located and special case agreement is negotiated to help cover the cost of mileage for the PCS workers commute to Andover, Kansas, where Billy lives. After confirming a new PCS start date, the care coordinator contacts Billy by telephone to confirm his PCS staff arrived as scheduled. Billy agrees to contact his community care coordinator immediately if there are any issues with the new PCS staff not reporting for scheduled shifts. Billy's care coordinator follows up again 14 days later to check in with Billy.

He reported that the staffing change is going well and he feels like the change was a good one for his family, as there is less tension and stress in the home.

After 45 days have passed, we do a warm transition from the transition specialist to a care coordinator experienced working with Members living with BIs. Billy, his UnitedHealthcare care coordinator and community care coordinator continue to meet regularly, during which Billy is assessed for any changes in SDOH needs, including food, housing or access to care. Billy is asked about his general well-being and any health concerns, progress toward goals or setbacks he has experienced. Billy attended each of his follow-up appointments with his PCP as scheduled. He has continued to make progress in all of his therapy goals. He reports that he has experienced a reduction in urinary incontinence episodes and has increased mobility and stability. He says that has been able to lose some weight with exercise and eating better. Therapy reports concur and indicate that Billy is motivated and a hard worker.

Billy's wounds were eventually healed through the use of in-home wound care, then outpatient services. With Billy spending less time sitting and more time being mobile, he is at less risk for redevelopment of wounds. Billy and his PCS staff have been well educated about the preventive care need to try to keep him free from future wounds, including good hygiene and skin care.

After six months being stable at home, Billy tells his care coordinator during one of his in-person meetings that he really wants to return to work. He enjoyed working before his accident and says he felt a sense of accomplishment and purpose when employed. The care coordinator and community care coordinator tell Billy about the STEPS (Supports and Training for Employing People Successfully) Program and the level of support the program can provide. Billy is interested in the program and excited about the possibility of assistance with pre-vocational skills and supportive employment once he has found a job. We provide a referral to the Kansas Department of Health and Environment's (KDHE) STEPS Program and to the working healthy benefits specialist (WHBS), who will complete a benefits counseling meeting with Billy so he can make an informed decision about his participation.

After meeting with the WHBS, Billy notifies his care coordinator and says he wishes to enroll in the STEPS Program. Billy understands that by choosing STEPS, he will not be able to access BI waiver-specific services; however, he will gain services through supportive employment and pre-vocational coaching. Billy is reassured that throughout this transition process from the BI waiver to STEPS, he will continue to be supported by his care coordinator and community care coordinator so this process is a smooth one and he continues to have full access to his resources.

Case Scenarios

31. Mary is a twenty-eight (28)-year-old, white, female who is incarcerated at a correctional facility serving a two (2) year sentence for a felony conviction. Her estimated release date is in two (2) weeks. Prior to her incarceration, Mary was enrolled in KanCare; however, her KanCare enrollment was suspended upon incarceration. Mary will be a Member of the bidder's plan upon release.

Mary has a history of schizoaffective disorder and substance use (marijuana and alcohol). She has been receiving medication for her mental health condition (Abilify and Depakote) throughout her incarceration but has not received treatment for substance use. Mary does not believe she has had or has a problem with substance abuse, though her prior usage led to her inability to maintain employment and housing.

Mary has "burned bridges" with her family and friends and will not have a place to live upon her release. She is, however, optimistic about her future and is willing to do "whatever it takes" to get back on track.

Describe the bidder's approach to planning for and addressing Mary's needs to support her successful re-entry into the community.

Women discharging from correctional facilities experience a higher level of recidivism than their male peers and are the fastest growing incarcerated population in the United States.[2] UnitedHealthcare has been collaborating with KanCare Members discharging from a correctional facility, including pre-lease transition planning, since 2015 and has active programs for justice-involved adults in Arizona, Nevada, Ohio and Washington. We understand the support and resources needed to create positive outcomes for Mary and Members like her.

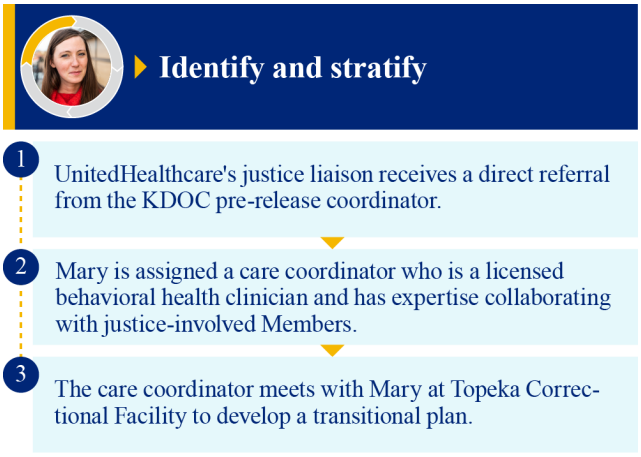
Our approach to supporting Mary's successful transition and helping her achieve her recovery and community integration goals includes:

- **Comprehensive transitional planning.** Work with the correctional facility staff to engage Mary in pre-release interventions and transitional planning to prepare her for rejoining her community upon release. This includes accurately identifying Mary's physical, behavioral and SDOH needs such as mental health and substance use treatment, housing, transportation and employment.

[2] Annual Report 2019, The Sentencing Project, Research and Advocacy for Reform, published in 2020, https://www.sentencingproject.org/app/uploads/2022/08/Annual-Report-2019.pdf (Downloaded Nov. 18, 2023).

- **Multi-system collaboration.** Proactively collaborate with Mary's Providers and justice system staff, inclusive of judges and probation, to support Mary's rejoining her community and to promote her ongoing recovery.
- **Promoting individualized, integrated, whole-person care.** Encourage Mary and help her to directly connect with a Community Mental Health Center/Certified Community Behavioral Health Clinic (CMHC/CCBHC) to address her behavioral health needs, providing a consistent medical Provider who is sensitive to her circumstances, and connect her to a community-based organization to address her SDOH and promote collaboration among these Providers.

Identify and Stratify



Mary is identified by a direct referral from Kansas Department of Corrections (KDOC) to our justice liaison after Mary obtains a Tier one presumptive eligibility determination from KDHE. Our justice liaison serves as a single point of contact for KDOC, including receiving referrals from the KDOC pre-release coordinator. The justice liaison also represents UnitedHealthcare in cross-system collaboration meetings designed to respond to the needs of justice-involved Members. The justice liaison receives important referral information from the release coordinator, including Mary's expected date of release, her desired discharge location and updated medical records.

The justice liaison contacts Mary's previous care coordinator, who is a licensed behavioral health clinician with justice and trauma-informed experience and notifies them that Mary will be a KanCare Member (upon her release). Upon receipt of the notification, the care coordinator reviews Mary's historical assessments in CommunityCare, our clinical management platform, and contacts the release coordinator to schedule a meeting to assess Mary's needs and to develop a transition plan in collaboration with Mary and the release coordinator.

Five days before her release date, the care coordinator meets with Mary in person at Topeka Correctional Facility to complete the Kansas Health Screening Tool (HST), a HRA and needs assessments to identify the services and supports Mary needs upon her return to the community. The care coordinator uses motivational interviewing techniques to identify and understand Mary's goals, individual wishes and needs. Mary shares mixed feelings about her upcoming release because she does not have anywhere to go and lacks a support system. Mary's care coordinator explains how the care coordination program provides support, including aiding with finding housing, setting up services, arranging transportation to appointments and connecting her to resources and peer supports.

The care coordinator proceeds to stress the value of developing a comprehensive transition plan and the importance of sharing information across different points in the health care, social service and justice systems, e.g., between the parole officer and care coordinator. Mary agrees and signs the closed-loop consent forms. Immediately, they begin the transition planning portion of their meeting, looping in the facility's pre-release coordinator. The care coordinator shares the

results of the assessments, Mary's personal life goals and some of her concerns. Together, they discuss the conditions of her parole, including the requirement that Mary attends a community-based 12-step program to address the alcohol and marijuana use, obtains a sponsor within the first week of release, resides in a sober living residence, follows behavioral health treatment recommendations, and attends scheduled check-ins with her parole officer. In addition, they discuss her support system and identify the services and resources Mary needs following release. During this discussion, the care coordinator learns that Mary has already applied for and been approved to start receiving Supplemental Security Income (SSI) payments upon discharge from the correctional facility.

Engage and Meet Urgent Needs

Based on the assessment and pre-release transitions meeting, the following transition plan is developed, which outlines the services and supports Mary needs upon her release, along with the actions taken by the care coordinator in the days leading up to her discharge:

- **Housing.** The care coordinator reviews available sober living locations in Wichita with Mary and helps Mary apply and be accepted at Robin's House Sober Living, a residence that is exclusively for females. As part of their program, Robin's House provides food and personal hygiene items.
- **Cellular phone.** To support Mary staying connected to her parole officer, care coordinator and her care team, the care coordinator orders a phone through Assurance Wireless at no cost to Mary. A plan is developed if Mary's phone is not yet delivered upon her release.
- **Transportation.** The care coordinator educates Mary on the nonemergency medical transportation (NEMT) benefit and explains the value-added benefit (VAB) that provides transportation for trips to her 12-step meetings, the grocery store and trips to meet with her parole officer. The care coordinator explained she can help arrange if needed.
- **Pharmacy.** Mary is discharged with a 30-day supply of Abilify and Depakote. The care coordinator connects Mary to Genoa Healthcare pharmacy for ongoing pharmacy services and continued medications to manage symptoms of her schizoaffective disorder. Genoa Healthcare, a UnitedHealthcare company, serves serious mental illness (SMI) populations in multiple states, including Kansas and provides high-touch, relationship-oriented pharmacy services to improve medication adherence.
- **Crisis and safety plan.** The care coordinator works with Mary to identify steps she can take when she if feeling overwhelmed and provides Mary with information on accessing COMCARE of Sedgwick County's CMCH/CCBHC 24-hour crisis services, which includes a mobile crisis unit and crisis stabilization beds.
- **CMHC/CCBHC intake**. The care coordinator schedules an appointment and transportation for Mary to complete an intake at COMCARE CMHC/CCBHC within 48 hours of her release.

- **Substance use.** The care coordinator, using UHC Community Connector powered by FindHelp, helps Mary locate a 12-step meeting schedule in Wichita and select a meeting close to her sober living residence, and arranges for transportation to the first meeting. The care coordinator supports Mary throughout and stresses the importance of attending weekly meetings, obtaining a sobriety sponsor within the week (per the conditions of her parole) and reminds Mary to use the transportation VAB benefit to attend future meetings.
- **PCP.** The care coordinator helps Mary select a PCP to address her ongoing primary, preventive and reproductive health needs. The care coordinator, in collaboration with Mary and her schedule, arranges appointments with her PCP within seven days of release, including arranging transportation appointments.

During this first post-release meeting with Mary at Robin's House Sober Living on the day following her release, the care coordinator discovers that Mary has settled in at Robin's House and has found the staff and other residents to be very welcoming to her. Mary agrees to sign a release of information for the care coordinator to be able to speak with the staff of Robin's House if needed. The care coordinator reviews the discharge transition plan and conditions of her parole with Mary. The care coordinator reminds Mary of her first 12-step meeting scheduled for later in the day and about the intake meeting that she is scheduled to attend at the CMHC/CCBHC tomorrow. In addition, the care coordinator confirms that Mary received her cellphone from Assurance Wireless and has been able to activate the phone, confirms that she is taking her medications as prescribed and reviews Mary's crisis plan with her.

In addition, based on the earlier pre-release conversation at the correctional facility about Mary's release anxieties and concerns, the care coordinator offers to connect Mary with a UnitedHealthcare certified peer support specialist (CPSS). CPSSs are individuals with personal experience with mental health or substance use disorder (SUD) and have at least one year of stable recovery. CPSSs support Members by talking them through life situations and demonstrating the use of various coping skills. The CPSS can help Mary navigate the recovery journey and behavioral health system and give her a sober system of support to fill social and environmental gaps. Mary is receptive to working with a CPSS and the care coordinator, during the meeting, connects her by telephone to the CPSS. The CPSS offers to speak with Mary following her CMHC/CCBHC appointment to see how it went; they exchange contact information. Mary's care coordinator concludes the visit by scheduling a follow-up care coordination meeting the following week but states that Mary can contact her at any time if she needs anything.

The day after the care coordinator's visit with Mary, Mary attends her CMHC/CCBHC intake, where her needs are further assessed, and an initial plan of service is developed in collaboration with her. The initial plan includes outpatient therapy services from a licensed clinician certified in trauma-informed cognitive behavioral therapy (CBT), an evidence-based treatment for those who have experienced trauma and are diagnosed with schizoaffective disorder. Mary receives medication management services from COMCARE. In addition, the intake clinician assesses that Mary is eligible for community support services and is assigned to a targeted case manager (TCM) who becomes Mary's primary point of contact at the CMHC/CCBHC. The intake clinician sets the initial appointments for therapy and medication management and informs Mary that her TCM contacts her to introduce themselves and to identify a time for the person-centered service plan meeting to develop Mary's plan of service. The intake clinician, following assessment and American Society of Addiction Medicine (ASAM) tool recommendations,

determines Mary does not need SUD treatment because she has been sober for the last two years while incarcerated and instead recommends that Mary continue attending the Alcoholics Anonymous 12-step community program.

Deliver Ongoing, Integrated Care

The next day, the TCM contacts Mary to introduce themself and to schedule a joint visit, with the care coordinator, at the sober living residence. At the visit, it is explained that the TCM becomes Mary's single point of contact for coordination of her services and supports, with our care coordinator working with the TCM to coordinate care.

The TCM and care coordinator review Mary's transition plan with her and ask about her intake at the CMHC/CCBHC. Mary stated that she liked the intake clinician and was pleased that she will not need to participate in SUD treatment outside her 12-step program. Mary added that she found a person to serve as her 12-step sponsor. In addition, Mary shared that she has adhered to her medications but in the past, she has skipped doses because the medications make her feel "numb and like she isn't a real person." Both the TCM and care coordinator listen without interruption and then offer suggestions on how Mary can address her medication concerns with her Provider. They also ask her to consider inviting the CPSS or TCM to attend her next medication appointment with her to provide support, and she stated that she prefers the CPSS to attend with her, which the care coordinator offers to help arrange.

The care coordinator encourages Mary to enroll in Genoa Healthcare's Adherence Program, a short-term program identifying Members with complex needs who are either nonadherent or at risk of medication nonadherence, regardless of pharmacy. This program contacts Members by telephone and facilitates access to prescribed medications. The Genoa Healthcare clinical pharmacist collaborates with the Member to understand their history of medications, thoughts and perceptions of medications, goals of therapy and any barriers to taking medications as prescribed. As needed, the Genoa Healthcare clinical pharmacist collaborates with the Member and their care team, including the dispensing pharmacy, to resolve any barriers and outline a plan for the Member to be adherent to the medication regimen.

Genoa Healthcare Adherence Program

When a person with BH conditions does not take their medications as prescribed, they put their health at risk. To address this concern, we introduced our Genoa Healthcare Adherence Program in Kansas in November 2021.

When comparing outcomes of Members receiving intervention in the first half of 2023 versus Members, we attempted to reach but could not, 73.7% were adherent to BH medications within 90 days of program enrollment compared with 43.8% of Members who were attempted but not reached.

At the end of the meeting, the TCM schedules a date and time for the initial person-centered plan of service meeting to develop Mary's plan of service, collaborating telephonically in advance with the care coordinator so both are present during the meeting. The TCM asks Mary who she wants to invite to the meeting. Mary decides in addition to her TCM and care coordinator, she is inviting her CPSS to attend along with her sobriety sponsor.

At the person-centered plan of service meeting, the TCM leads the group discussion, which includes a status review of Mary's transition plan and recommendations from Mary's CMCH/CCBHC intake appointment and care coordinator assessments. Based on a review of services and options available, Mary agrees to the following plan of service:

- Individual therapy using trauma-informed CBT
- Medication management
- Targeted case management
- Community psychiatric support and treatment (CPST)
- Additional supports and services are added to the plan of service:
  - Genoa Healthcare's pharmacy services and medication adherence program
  - UnitedHealthcare CPSS
  - 12-Step program
  - Robin's House sober living
  - Mary's PCP
  - Transportation benefits through UnitedHealthcare
  - Mary's crisis and safety plan
  - Seeking Safety

Seeking Safety

Seeking Safety is a VAB that is an evidence-based, present-focused counseling model, provided in an individual or group setting, which helps Members attain safety from trauma and/or substance use. Seeking Safety is promoted by SAMHSA and known for its relevance into vulnerable populations, including homeless, criminal justice, domestic violence, people living with HIV, severe and persistent mental illness, veterans and active-duty military. **UnitedHealthcare is the only organization in Kansas authorized to train peers to facilitate Seeking Safety.**

Due to the level of Mary's service needs, she will receive at least one monthly telephone contact from the TCM and care coordinator, including face-to-face visits every other month, with additional contacts being made as needed. The care coordinator and TCM explain that they work together to coordinate these contacts at a time and day that is convenient for her. To support alignment and to avoid duplication of services, the TCM presents the completed plan of service for final review and advises that a copy is forthcoming for authorized stakeholders. Mary provides her consent for the plan of service to also be shared with her parole officer.

Tracking Progress and Recognizing Change

Once Mary has achieved a period of stability in her life and has maintained a consistent routine of attending treatment and meeting her parole requirements, which are critical elements to her ongoing success, Mary develops and begins working toward her longer-term goals, including:

- Finding employment
- Locating permanent housing to prepare for when it is time to move from her sober living residence
- Reconnecting with family to develop an ongoing source of social support

To assist Mary in achieving her vocational goals, the care coordinator and TCM

encourage Mary to enroll in the Supported Employment Case Management Program at COMCARE. The program provides ongoing supports such as career exploration and help applying for financial assistance for pre-employment coursework, to through her educational or employment process. In addition, Mary can receive a VAB incentive to participate in education.

Housing Kansans

Over **1,000** KanCare Members have **received housing navigator assistance** since we added this position in early 2019.

To address Mary's goal of finding stable and permanent housing, the care coordinator offers to enlist the assistance of UnitedHealthcare's dedicated Kansas housing navigator to initiate a housing consultation. Our housing navigator builds relationships with property owners and identifies resources to help with housing vouchers, move-in support, security deposits and other needs. Mary agrees to this referral, and the housing navigator works with the care coordination team to identify resources for Mary, including low-income housing through property owners typically willing to collaborate with individuals that have convictions. After discussing with her therapist, Mary has decided to contact her half-brother, with whom she had a strong relationship when the two were growing up but became estranged during early adulthood. Mary shares she spoke on the phone with him and have plans to meet for coffee soon.

Now six months post-release, Mary continues to meet the conditions of her parole, including participating in regular 12-step meetings, maintain regular contact with her sponsor and has been adherent with her treatment plan. Enrollment in the Supported Employment program at COMCARE, she is taking classes to become a certified nursing assistant (CNA). Mary has also applied for her own housing through Section 8 and is on the waiting list for several locations in the Wichita area. Mary reports feeling pride of her accomplishments and gratefulness for the support and assistance she has received from her Providers, her community and from UnitedHealthcare. Even more importantly, Mary expresses hope for her future.

Helping a Member Like Mary: Jane's Story

Situation: Jane is a 48-year-old female Member who was recently released from a county jail in rural Kansas. Before her incarceration, Jane was a UnitedHealthcare Member, and after her release, Jane called UnitedHealthcare's member services to ask about getting a phone. After listening to her request and completing the Kansas HST, member services referred Jane to our integrated care coordination team for further assessment. The CHW assigned to Jane completed an HRA and discovered that Jane has a history of BH needs, including SUD, and that Jane was recently released from jail to an unsafe living environment.

Intervention: The CHW helped Jane apply for a phone through Assurance wireless and locate a PCP who could see her immediately to get her anti-anxiety medication refilled. Unfortunately, Jane missed the appointment. With Jane's permission, the CHW contacted the PCP's office to explain Jane's situation and rescheduled her appointment. Jane kept this appointment and refilled her prescription. The CHW next worked with Jane to help her relocate to a safer living situation - helping her find an extended stay hotel near her sister's residence in a nearby rural community that she could afford and assisting her as she applied for low-income housing. The CHW enlisted one of our BH care coordinators, who is a licensed BH clinician, to help connect Jane to the local CMHC/CCBHC to address her BH needs. As part of her services at the CHMC/CCBHC, Jane participated in court-ordered anger management classes. Finally, the CHW worked with Jane to obtain a new payee that is easier for her to work with and referred her for an HCBS waiver eligibility determination.

Outcome: Jane established care with her PCP and CMHC/CCBHC and is now on the waiting list for the Physical Disability waiver. Her sister can check in on and provide support to her while she awaits long-term housing.

Case Scenarios

32. Pedro is a seventeen (17)-year-old, Latino, male KanCare Member living in foster care. Pedro was diagnosed with asthma at four (4) years old and uses an inhaler to manage his symptoms, with varying success.

At his last health care visit, Pedro and his foster mother shared with Pedro's Primary Care Provider (PCP) that Pedro is having more difficulty breathing and more frequent asthma attacks. When the PCP inquired about the precipitating circumstances, the PCP learned that the breathing problems and asthma attacks have been occurring when Pedro is at home — not at school or other locations, leading his PCP to think that there may be an environmental trigger in the home. Pedro has had four (4) ED visits in the last twelve (12) months due to his asthma. Pedro's case file also states he experienced significant physical and emotional abuse during his early childhood, resulting in his placement in foster care. Pedro was once active in school and extracurricular activities but recently has become more withdrawn, leading his foster parents to suspect marijuana or other substance use, which they have expressed to his PCP.

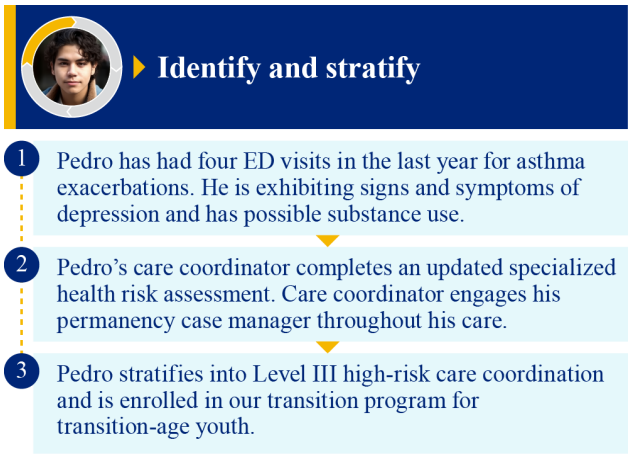
Pedro's PCP has contacted the bidder's Care Coordination team to request assistance with assessing and addressing the potential environmental trigger exacerbating Pedro's asthma, and to make the care coordinator aware of Pedro's possible behavioral needs.

Describe how the bidder will respond to the PCP's request and how the bidder will support and coordinate Pedro's health needs.

UnitedHealthcare understands that all children in foster care have experienced trauma in the events that precipitated their foster care placement, during the experience of separation from their biological family and the foster care experience itself. Through our experience serving more than 42,000 children in the foster care population in 19 states, including 63,000 KanCare foster care youth since 2013, we know that without strong supports these young people are at increased risk for homelessness, poverty and unemployment.[3] Established on our extensive child welfare experience our integrated, trauma-informed, culturally responsive, attachment-based specialty foster care program focuses on the strengths and resiliency of children, youth and families while fostering stability and permanency. To support Pedro's needs, our approach is to assess his asthma and behavioral health (BH) conditions, stabilize these conditions, provide education and support to both Pedro and his caregivers for his conditions and, given he is 17 years old, continue to help with his transition into adulthood.

[3] Troubling Outcomes of Youth Transitioning From Foster Care - The Annie E. Casey Foundation (aecf.org).

Identify and Stratify

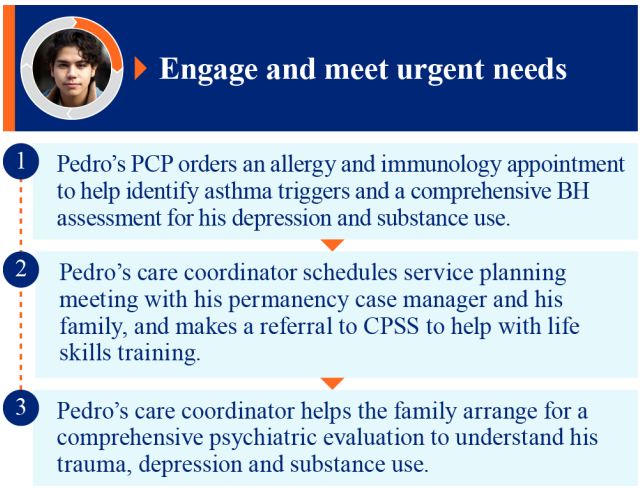


As a child in foster care, Pedro has been a UnitedHealthcare Member enrolled in care coordination since this foster care placement. Because of his repeated emergency department (ED) visits, his poorly controlled asthma, pending transition to adulthood and assessment needs for his ongoing trauma and possible substance use, Pedro is currently in Level III care coordination for Members with high-risk, complex needs. At this level of care coordination, Pedro has a care coordinator who has a master's degree in social work and specialized training in trauma-informed care concepts, including safety, trustworthiness and transparency. His care coordinator is cross-trained in medical, behavioral, functional and health-related social needs. Pedro's care coordinator remains consistent with Pedro regardless of his level of care coordination and will meet with him in person at least monthly to make sure he has the resources and services he needs.

Pedro's care coordinator has established a collaborative relationship with Pedro's permanency case manager at St. Francis Community Services, the case management provider for the region. The care coordinator has received authorization from the permanency case manager to freely communicate with Pedro's foster mother regarding Pedro's care and needs, and the care coordinator has developed a strong rapport with Pedro and the foster mother.

After Pedro's PCP contacted the care coordinator with concerns about environmental triggers contributing to Pedro's acute asthma symptoms, and to address BH concerns, the care coordinator schedules an in-person visit at a time convenient for Pedro and his foster mother at their home within seven days of speaking with the PCP.

Engage and Meet Urgent Needs



During the visit, the care coordinator discusses with Pedro's foster mother how his asthma is currently being managed. She shares Pedro has had an asthma management plan since his diagnosis and has been using a peak flow meter, and the Easy Peak Flow Diary app to track his readings on his phone since he got his phone last year. His Provider updates his asthma action plan following each visit. Pedro's foster mother knows the PCP is concerned with the frequent ED visits. When asked about any changes to the home environment over the last year, Pedro's foster mother shares that she cannot think of anything other than the family cat has taken up residence in Pedro's room and has been sleeping

with him. To help mitigate the potential environment trigger, the care coordinator asks Pedro and his foster mother if they would be willing to restrict the cat's access to Pedro's room by asking him to keep his door closed to his bedroom and to not allow the cat to come into the room at night to sleep with him. Pedro and his foster mother agree to this interim plan.

Pedro's foster mother also shares she is concerned with his recent change to his behaviors sharing he was involved with extracurricular activities and now he is withdrawn, spending most of his time while at home in his room.

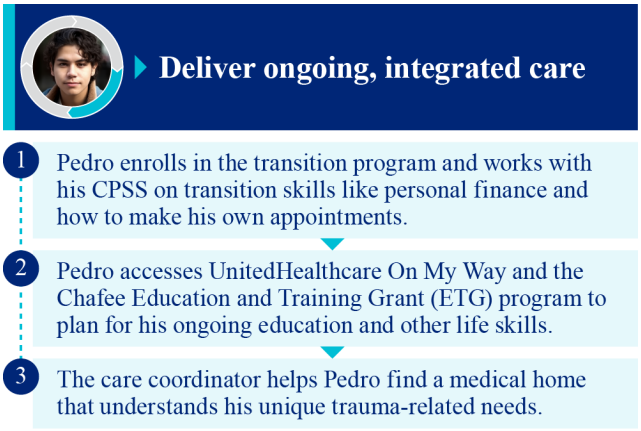
After meeting with Pedro's foster mother, the care coordinator meets with Pedro alone in the kitchen. As Pedro grabs an after-school snack, his care coordinator, using established rapport with Pedro engages him in conversation. The care coordinator, who is also Latino, can usually easily engage Pedro in conversations about their favorite soccer team, Cruz Azul and asks if Pedro watched their last game. Surprisingly, Pedro says he is not watching much. When asking about school, Pedro shares school is useless, and he does not learn anything. He also shares he is tired of being in foster care, knows that everyone will be glad when he turns 18, but he does not know what he will do when he has to leave this foster home. Recognizing Pedro is struggling to process his feelings about transitioning to adulthood and what that means for his life and with the depressive symptoms he acknowledged in the HRA, the care coordinator suggests Pedro could talk with someone who can help him sort things out. Pedro shares he has talked with someone before and agrees to try that again.

Following the home visit, the care coordinator calls Pedro's PCP office and shares information obtained during the home visit. Together, they outline an interim treatment plan. Pedro's care coordinator connects with his permanency case manager to discuss the updates to Pedro's plan, including his updated HRA. His permanency case manager schedules a team decision-making meeting, which Pedro, his foster family and his care coordinator attend. Together, the team outlines a plan to address Pedro's most urgent needs, including:

- Allergy testing for possible environmental trigger with network allergist identified by the care coordinator
- Comprehensive psychological evaluation with a trauma-informed BH Provider to evaluate Pedro for trauma-related symptoms, psychological disorders and substance use
- Peer mentoring through UnitedHealthcare with a former foster youth who is Latino, enabling connection with Pedro through sharing life experiences and to help reinforce trauma-informed coping skills

Deliver Ongoing, Integrated Care

The care coordinator receives an update from Pedro's PCP's office regarding the results of Pedro's allergy testing, which confirms that the environmental trigger for Pedro's acute asthma symptoms is the pet dander from the family cat. Fortunately, the nurse reports that there are steps Pedro's foster family can take to control pet dander through such activities as frequent vacuuming and dusting. In addition, the nurse recommends that the



family obtain a high-quality air purifier with a HEPA filter. The care coordinator requests that the PCP write an order for the air purifier and submit a request for prior authorization coverage under the State's KanBeHealthy program. Finally, the PCP recommends that the family restrict the cat's access to Pedro's room and that Pedro no longer allow the cat to sleep with him.

Following his comprehensive psychological evaluation diagnosis of trauma-related depression, Pedro's care coordinator, permanency case manager, and foster mother work together to reconnect Pedro with a therapist in Salina he had worked with at the beginning of his placement with this foster family until therapy was stopped because Pedro was doing well in school and at home. Pedro's permanency case manager had selected this therapist because they specialized in helping youth in foster care heal from the impact of trauma, was experienced in collaborating with the permanency case manager and with the foster care system, and demonstrated cultural competence in their practice.

Before Pedro's first appointment with his therapist to restart therapy services, Pedro's the care coordinator calls the therapist's office and asks the therapist for a call before Pedro's first therapy session. The therapist returns the care coordinator's call as requested. The care coordinator shares Pedro's foster mother's concerns that Pedro may be using marijuana or other substances. The therapist thanks the care coordinator for sharing this information noting that they will address this issue with Pedro during assessment of his current BH needs.

During a weekly therapy session, Pedro discloses that he has been smoking marijuana several days a week during the last few months. He tells his therapist that the uncertainty of life after foster care makes him stressed and the only thing that helped him cope with the emotions that accompanied them was smoking marijuana.

Pedro expresses frustration that he does not know why he could not have a normal life like other teenagers he knows. After actively listening to Pedro's description of his experience, the therapist expresses appreciation to Pedro for disclosing this information to him. The therapist explains to Pedro that it is understandable that he is worried and stressed about his future and emphasizes it is critical for him to actively work on managing his stress to begin making plans for what will be next in his life. Pedro agrees to attend weekly therapy sessions to continue processing his emotions and fears.

The therapist also tells Pedro that he would like to refer him for a drug and alcohol assessment at Central Kansas Foundation, an SUD treatment center in Salina. He explains to Pedro that the marijuana use not only negatively impacts his emotional health, it also may contribute to exacerbating his asthma symptoms. Pedro reluctantly agrees to participate in the drug and alcohol assessment.

The therapist also asks Pedro if he is agreeable to sharing the information about his marijuana use with his care team, as it is important that Pedro's PCP is aware of this information due to the possibility that it is further exacerbating his asthma symptoms. Pedro is agreeable. After finishing his session with Pedro, the therapist shares the information regarding Pedro's drug use with his foster mother and later contacts the care coordinator to share the same information. The care coordinator updates his PCP about Pedro's drug use and contact's Pedro's permanency case manager to share this information and obtains consent for Pedro to receive an SUD assessment at Central Kansas Foundation.

Later that week, Pedro attends an SUD assessment at Central Kansas Foundation, which determined Pedro needs an outpatient level of treatment that includes both individual and group SUD counseling. Pedro agrees to participate, and his foster mother arranges for services to begin.

Pedro's care coordinator calls to follow up with him and his caregivers weekly to monitor his asthma and BH treatment. During these calls, he reports that he has been taking his medications and using the app to track his peak flow readings. His caregivers report that he has not had any more visits to the emergency department. During one of his every other month in-person visits, Pedro reports that he still feels depressed sometimes and is working on this in therapy. He reports that he is worried about what will happen when he turns 18 because he is nervous about the possibility of leaving his foster family and having to face the world as an adult. He relates that even though he has been working on some skills like money management with his CPSS, he feels more alone, sad and worried.

Since Pedro is a transition age youth, he is enrolled into our transition program that helps youth prepare for their transition into adulthood. As part of this program, Pedro's care coordinator engages him in a transition into adulthood assessment, which helps determine Pedro's level of strength and need in different life skill areas, including understanding his health care needs. Based on the assessment, Pedro's care coordinator provides specialized transition services focused on his health care and life skills. Through our program, he receives these additional supports:

Peer Support: Pedro's care coordinator provides him with a personal introduction to one of our certified peer support specialists (CPSSs). The CPSS is a Latino former foster youth who will connect with Pedro through sharing life experiences and help reinforce trauma-informed coping skills. The CPSS will assist Pedro with learning life skills he says are important to him, such as managing his own finances and scheduling his therapy appointments. His CPSS and care coordinator partner with his permanency case team to assist with coordination of independent living and educational services to best suit Pedro's needs and strengths.

On My Way: To assist with transitioning into adulthood, Pedro's care coordinator helps him access On My Way, which is a digital app that helps youth explore money management, transportation, health care, vocation, housing and education skills in a gamified manner, offers links to state resources such as education and training vouchers through the Chafee Education and Training Grant Program. On My Way helps Pedro obtain documents (e.g., birth certificates, Social Security cards and driver's licenses), all things he will need to manage his own life into adulthood. As Pedro transitions into adulthood, it is important to help him find a medical home that understands the unique needs of youth, like Pedro who have been in foster care and have a history of trauma. We work with Pedro to help him understand his role in the health care system, self-advocacy and rights as he ages and transitions into the adult health care system.

Pedro's care coordinator partners with his permanency case manager for his transition planning meetings. During these meetings, his care coordinator shares the results of his transition into adulthood assessment and updates his individualized care plan to include services he will need, care team changes and other supports such as transportation. Pedro and his team discuss a plan where Pedro will begin to gradually schedule his own appointments and his care coordinator will monitor these as he feels more confident. He feels confident in scheduling his therapy appointments as he and his CPSS have been working on this skill. Pedro expresses sadness and worry about what will happen when he turns 18. His foster parents express that he can stay with

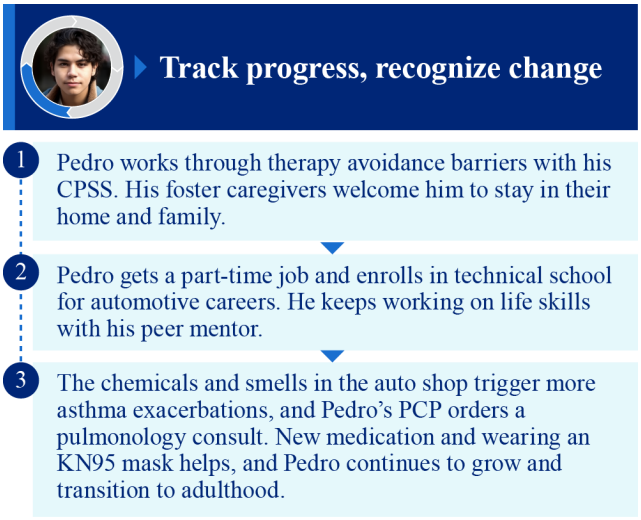
them if he chooses, and his permanency case manager and independent living specialist explain the extended foster care program.

Part of transition planning includes education or employment goals. Pedro is interested in auto mechanics since auto shop was his favorite class. His care team explains to Pedro that once he finishes school, he can apply for an education and training voucher and Chafee resources to engage in an auto mechanic training program and internship through one of the community colleges. Pedro also expresses interest in getting a part-time job. His care coordinator explains through UnitedHealthcare he can work with an employment specialist who will help him look for opportunities related to auto mechanics.

Together with Pedro, his independent living specialist, permanency case manager and foster caregivers, the team identifies the following for transition planning support Pedro will receive:

- Support with scheduling annual KanBeHealthy/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) medical, vision and dental appointments until he is 21
- Assistance identifying qualities he likes in his Providers so that as he approaches 21, they identify a family physician or internist and therapist he feels confident transitioning to for care as an adult
- Assistance with scheduling transportation for appointments when needed through Transportation Hub

Track Progress and Recognize Change



Pedro's care coordinator and CPSS continue to monitor his progress and contact Pedro weekly by phone and text as he prefers. The UnitedHealthcare employment specialist helped Pedro get a part-time job at AutoZone. He expresses excitement about this job; however, he relates that he has not been going to therapy because he cannot find time between work and school. He has been missing some therapy appointments and his CPSS uses motivational interviewing with Pedro and learns that he has been avoiding therapy since it started because he did not want to talk about his trauma. His CPSS validates these feelings and encourages Pedro to talk with his team about this concern. Pedro, with the help of his CPSS, discusses his avoidance of therapy, including his group sessions for his SUD with his care coordinator, foster mother and permanency case manager. Pedro tells the care coordinator that he is willing to re-engage with his therapist but is not yet ready to talk about his trauma. He expressed feeling relieved about not moving houses, but still feeling depressed and still being very worried about adult life in general, which has made it hard to concentrate on studying. He related that he got into trouble at work for dropping tools and messing up. Pedro's care coordinator engages the employment specialist again to connect Pedro with vocational rehabilitation services to determine if accommodations at work may be useful given his major depressive disorder.

For the next several months, the care coordinator continues to monitor Pedro's progress with phone calls and monthly visits. When spring arrives, Pedro graduates from high school and enters the auto mechanics program, his asthma begins to flare again. Pedro and his care coordinator discuss potential triggers in the environment that may be exacerbating his asthma. He thinks chemical odors are affecting him. Unfortunately, he is unsure what to do to help with this issue. His care coordinator recommends he ask his PCP for guidance. The PCP refers Pedro to a pulmonologist. The pulmonologist starts Pedro on a new medication, Symbicort, with a spacer so he can absorb sufficient medication and reminds him when to use his rescue inhaler. The pulmonologist also suggests Pedro wear a KN95 mask, which he can obtain through his EPSDT DME benefit. The care coordinator reviews information with him about the peak flow guidelines when he should seek additional instruction and when to call 911.

During follow-up visits, Pedro and his caregivers report things have improved. He notes that he has not had additional asthma attacks now that he is wearing a mask. He relates that he is re-establishing rapport with his therapist and feels comfortable there. Pedro says he has started saving money for an apartment and shows the budgeting sheet he worked on with his CPSS. His care coordinator reaches out to his independent living specialist who confirms Pedro is on track to continue with his education and training voucher for his education since he is earning good grades in technical school.

Since Pedro is continuing in extended foster care and is doing well with self-management of his asthma, reports he has not used marijuana in several months and continues engagement with his therapist, he will continue in care coordination at Level II. At this level, his care coordinator will check in with him by phone monthly and see him for in-person visits every three months. His care coordinator reminds Pedro at every contact that he can reach out anytime.

Helping a Member Like Pedro: Dominick's Story

Dominick is 19 years old and is a former foster care youth. At age 12, while in foster care, Dominick demonstrated inappropriate sexual behavior and was placed at Parson's State Hospital for intensive inpatient treatment. Dominick's treatment team included the Parson's State Hospital staff, the St. Francis Foster Care agency permanency placement worker, the Sedgwick County Community Developmental Disability Organization and targeted care manager. In 2021, having successfully addressed his inappropriate behavior, the UnitedHealthcare community transition team supported Dominick's transition to the State's IDD waiver and community placement using Rescare, a Wichita-based placement resource. His UnitedHealthcare care coordinator worked with Dominick and the team to complete necessary assessments and make sure his health care needs were met. Today, Dominick has been released from foster care, has a new guardian in place, and is living successfully in the community.

Case Scenarios

33. Henry is a twelve (12)-year-old, white, male KanCare Member who has complex medical needs, including significant IDDs with co-occurring severe Behavioral Health issues. In recent months, Henry has become increasingly aggressive towards other people and the family pet, with behavioral episodes that are both more frequent and more severe. These episodes have resulted in repeated crisis interventions, visits to the hospital ED, inpatient psychiatric stays, and calls to law enforcement. Henry's most recent episode of aggression resulted in his current stay in a psychiatric hospital.

Henry's mother, Shauna, is a single parent to Henry and his two (2) younger siblings, a brother who is eight (8) and a sister who is five (5). Shauna has been very involved in and supportive of Henry's treatment. While Henry has not harmed his siblings to date, his increasing aggression has left her afraid both for her own safety and the safety of her other children.

As part of the planning for Henry's discharge from inpatient psychiatric care, Shauna requested residential treatment for Henry to stabilize his Behavioral Health condition and work on managing his aggressive behaviors before Henry is returned to her home. The team involved in Henry's discharge planning is encountering difficulties in identifying an appropriate and available placement option to meet Henry's IDD and behavioral health needs. The inpatient facility is pressing for the Member's discharge and has suggested intensifying outpatient services until a suitable placement is available. Shauna has stated that while she wishes things were different, she is unable to allow Henry to return home in his current condition — that the threats to the safety of the family have grown to an unacceptable level, and that if forced, she will request that he be placed in state custody.

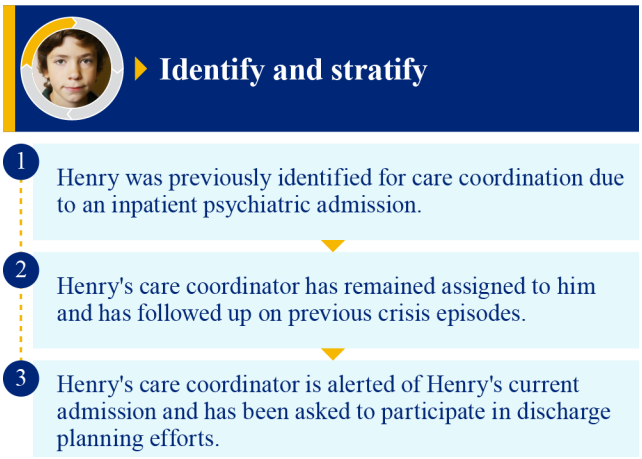
Since 2013, UnitedHealthcare has been working with KanCare Members with intellectual and developmental disabilities (IDD), and with Members on the IDD waiver since 2014. Today, 7.87% of KanCare children who have IDD have serious emotional disturbance (SED). Nationally, it is estimated that only one in 10 youth with co-occurring IDD and behavioral needs receive individualized behavioral health (BH) treatment that considers their IDD diagnosis,[4] and less than half of their families report satisfaction with their

[4] Concurrent Disorders, by the Centre for Addiction and Mental Health, https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/concurrent-disorders (downloaded 12/7/23).

treatment Providers.[5] Responding to these Members' needs requires a flexible, collaborative and cross-systems approach that considers their individualized needs. Our approach to meeting Henry and his family's needs includes the following:

- Engaging in collaborative and comprehensive discharge planning with the discharging inpatient facility, including conducting a UnitedHealthcare specialized process called Reducing Admissions through Collaborative Interventions (RACI) to identify Henry's needs and barriers at discharge. [redacted]
- Developing and implementing a comprehensive crisis and safety plan in collaboration with Henry's care team to address Shauna's safety concerns and decrease the likelihood of unplanned inpatient admissions and continued ED visits.
- Making sure Henry and his family receive comprehensive wraparound services and that Henry's Providers are equipped to meet his complex needs. To support Henry, his family and his service Providers, UnitedHealthcare uses Skill System, an intervention that teaches emotional self-regulation and co-regulation skills to individuals, their caregivers and their Providers. This intervention has demonstrated effectiveness with individuals who have co-occurring IDD and mental health conditions.

Identify and Stratify



Henry was first identified for the UnitedHealthcare care coordination program and enrolled due to a previous psychiatric admission. Henry was assigned a care coordinator who is a licensed BH clinician with several years of experience collaborating with individuals who have co-occurring IDD and BH needs. Due to the complexity of his needs and repeated crisis episodes, Henry's care coordinator has continued collaborating with him since that first psychiatric admission. The care coordinator, through completion of assessments, has learned that Henry was previously diagnosed with IDD, intermittent explosive disorder and Type 1 diabetes. Shauna reports that Henry resists having his blood sugar checked and his insulin administered and struggles with healthy eating necessary to control his diabetes.

Henry's care coordinator had previously referred him to High Plains Mental Health (High Plains), a Community Mental Health Center and Certified Community Behavioral Health Clinic (CMHC/CCBHC) in the Hays area. The referral was for an SED waiver assessment and community-based BH services to supplement the care Henry is receiving through his private

[5] Experiences With the Mental Health Service System of Family Caregivers of Individuals with an Intellectual/Developmental Disability Referred to START, by the University of New Hampshire, Scholars Repository, https://scholars.unh.edu/iod/167/ (downloaded 12/7/23).

outpatient therapy provider with whom he and Shauna had developed a strong working relationship. However, Shauna had declined this referral, choosing instead to remain exclusively with the outpatient therapy provider. In addition, the care coordinator referred Henry and Shauna to Developmental Services of Northwest Kansas (DSNWK), the Community Developmental Disabilities Organization (CDDO) in the area, to complete a Basic Assessment and Services Information System (BASIS) assessment used to determine functional eligibility for the IDD waiver. When making the referrals, the care coordinator had explained to Shauna that Henry can only be on one home- and community-based services (HCBS) waiver. However, if Henry were approved for the SED waiver, he also potentially qualifies for the IDD waiver waitlist to address his long-term IDD needs in adulthood. To date, Shauna and DSNWK had not scheduled an appointment to complete the BASIS.

Henry's care coordinator receives an alert regarding Henry's current inpatient psychiatric admission at Camber through UnitedHealthcare's electronic clinical management system. The BH utilization management care advocate (CA) assigned to Henry's case also notifies the care coordinator of Henry's admission to assist with discharge planning. One CA is assigned by UnitedHealthcare to each inpatient psychiatric facility, including Camber, allowing for a single point of contact between the hospital and UnitedHealthcare, promoting a collaborative relationship between UnitedHealthcare and the facility.

Engage and Meet Urgent Needs

Due to Henry's repeated psychiatric admissions, including his complex and co-occurring BH and medical needs, the CA initiates a request for an RACI discussion before discharge. RACI is UnitedHealthcare's interdisciplinary collaborative approach for decreasing acute BH inpatient readmissions and increasing community stability for Members with complex needs. Since its implementation in 2020, RACI has resulted in improved communication with inpatient staff, increased goal-focused collaboration that has broken down silos of community care, and provided proactive identification and management of the individual's needs and improved provider relationships. The recommendation from the RACI meeting is to revisit with Shauna a referral to High Plains for community-based services and an SED waiver assessment, and that a comprehensive crisis plan to de-escalate crisis episodes and prevent continued readmissions be developed before discharge.

In addition, at Shauna's request, Camber had contacted High Plains Mental Health and arranged for a High Plains clinician to come on-site at Camber to meet with Henry and Shauna to complete a screen for admission to a psychiatric residential treatment facility (PRTF). The High Plains clinician completed the screen and determined that Henry is eligible for PRTF admission. However, the facility has since sent referrals to area PRTFs, and each facility except for Lakemary declined the referral, stating that Henry is not a candidate for their program due to his complex medical and IDD needs. Lakemary further communicated that they have an extensive

waitlist for admissions and was unable to identify a date when the facility would have a bed available to admit Henry. This information was noted to review with Shauna, along with the RACI recommendations, during an upcoming discharge planning meeting.

Our care coordinator and CA then collaborate with Camber's discharge planner to schedule a discharge planning meeting that includes Shauna, the facility, High Plains Mental Health, Henry's current outpatient therapist, as well as our care coordinator, CA and UnitedHealthcare's behavior health medical director. Henry's PCP is also invited but is unable to attend. During this initial discharge planning meeting, the care coordinator explains to Shauna that, despite meeting criteria for PRTF admission, Henry is placed on the PRTF waitlist due to lack of available beds to meet his needs. It is further explained that while Henry is on the waitlist, assessments are required every 60 days to make sure he continues to meet criteria for PRTF admission.

The care coordinator also explains the recommendations resulting from the RACI, including a referral for SED waiver assessment at High Plains, development of a comprehensive crisis stabilization and safety plan and adding wraparound services and supports on discharge. The care coordinator adds that High Plains has experience working with youth who have co-occurring IDD and BH needs, due to their participation in the Skills System training offered by UnitedHealthcare.

Shauna responds that she understands the options and is appreciative of everyone's efforts. However, she remains concerned for the safety of her children and the family pet if Henry returns home before completing residential treatment. Based on this expressed refusal by Shauna to allow Henry to return home, Camber contacts the Kansas Department for Children and Families (DCF) to file child protective services report pursuant to established facility protocols. The next day, DCF outreaches to Shauna regarding the report. During the discussion with DCF, Shauna reinforces that she wants Henry to return home but is scared that he will harm his younger siblings and the family pet if he is discharged home. The DCF worker expresses understanding of her fears and explains that DCF's goal is to provide support to Shauna and the family. The worker reviews the prevention services available through DCF, including Family Preservation Services.

The care coordinator works with the CA and Camber to arrange another discharge planning meeting, taking place the day after Shauna's discussion with DCF. This time the meeting includes DCF, the Kansas Department for Aging and Disability Services (KDADS), Henry's school and DSNWK, in addition to the prior participants. During the meeting, services and support available to Henry and Shauna are reviewed. Shauna remains hesitant for Henry to return home but understands that Henry is unable to stay in the hospital while he awaits a bed opening at Lakemary. She also does not want Henry sent to a facility outside Kansas where it is difficult to visit him. Further, Shauna does not want Henry to transition into State custody and moved to an out-of-home placement. Shauna agrees to allow Henry to discharge home with the DCF recommended Family Preservation Services, intensive community-based wraparound services and a robust crisis stabilization and safety plan that considers his behavioral and medical needs.

Due to Henry potentially qualifying for the IDD and the SED waiver, both High Plains and DSNWK explain the services available to Henry through each waiver. Shauna chooses to pursue getting Henry assessed for the SED waiver, as these services meet Henry's existing needs, but

she adds that she will complete the BASIS as well, to allow Henry to be placed on the IDD waiver waitlist in anticipation of his long-term and adulthood needs.

The discharge plan includes a strategy for helping Shauna manage Henry's diabetes. The care coordinator explains that with a request from Henry's PCP, UnitedHealthcare can request a continuous glucose monitor (CGM) through the State's KanBeHealthy program. Shauna agrees to this, and the care coordinator helps Shauna with reaching out to Henry's PCP to make this request. The following outlines the finalized discharge plan for Henry and his family.

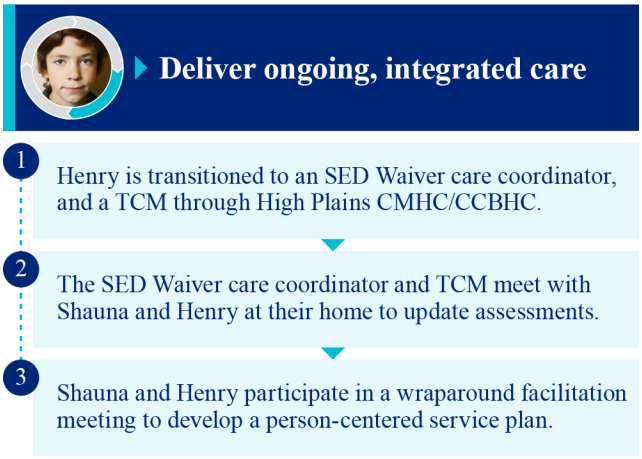
Camber Discharge, Safety and Crisis Plan – Address Henry's Immediate Needs		
Service	**Goal**	**Interventions and Solutions**
Family Preservation Services – DCF - Six weeks - Ongoing, weekly interactions	Reduce the risk of Henry being placed in out-of-home placement and away from his natural support system	▪ Henry and his family participate in intensive in-home Family Preservation Services by a master's-level practitioner with the intent to mitigate immediate child safety concerns, stabilize family crisis and assess the family's needs
High Plains Mental Health - Within 24 hours of discharge from Camber	Provide intensive, outpatient community-based BH services and reduce unnecessary hospitalizations, readmissions or other inpatient treatments	▪ Henry to receive the SED waiver assessment ▪ Henry and his family to participate in outpatient and community-based wraparound services, including SED waiver services, with an emphasis on using Skills System ▪ Medication Management Services, as Henry has been placed on a low level of Lexapro to help him manage his aggressive impulses
Crisis and Safety Plan - Available 24 hours a day, seven days a week - Request as needed	Stabilization and safety planning within a natural setting, including communication and coordination between Shauna, Henry, the care team and co-responders to limit unnecessary law enforcement contacts and ED visits, while promoting a safe environment for Henry and his family	▪ High Plains crisis response helpline that provides 24 hours a day, seven days week access to mental health professionals ▪ High Plains has trained local law enforcement to respond to mental health crisis ▪ Family Preservation Services provided by a master's-level practitioner with the intent to mitigate immediate child safety concerns, stabilize family crisis and assess the family's needs; includes 24 hours a day, seven days a week in-home crisis response ▪ Family Preservation Provider for region is TFI Family Services

Camber Discharge, Safety and Crisis Plan – Address Henry's Immediate Needs		
Service	**Goal**	**Interventions and Solutions**
Plan to Manage Henry's Diabetes	Manage Henry's Type 1 diabetes	▪ Request approval of CGM to be covered by KanBeHealthy

The care coordinator helps Shauna schedule the intake appointment at High Plains for the day after Henry's discharge from Camber. The care coordinator asks Shauna if she needs any help with transportation, and Shauna reports that she does not. In preparation for the assessment, the care coordinator informs Shauna that Genoa Healthcare, a UnitedHealthcare company, has an embedded pharmacy at High Plains. Genoa Healthcare provides high-touch, relationship-based pharmacy services to improve medication adherence. The care coordinator and Shauna also discuss the value of transitioning to a High Plains therapist to maintain a consistent approach in using Skills System, and the care coordinator helps Shauna with the transition of therapists.

The day after his discharge from Camber, Henry and his mother attend his intake at High Plains. A High Plains clinician completes the SED waiver assessment and determines that he qualifies for the SED waiver. Henry is assigned a targeted case manager (TCM) by High Plains to function as the family's primary point of contact for coordination of services. Henry is scheduled for a future medication evaluation at High Plains and is assigned to an outpatient therapist to provide individual and family therapy for Henry.

Deliver Ongoing, Integrated Care



Henry transitions over to the SED waiver and is assigned an SED waiver care coordinator from UnitedHealthcare, one with several years of experience collaborating with Members who are enrolled in the SED waiver and with expertise regarding SED waiver services. The care coordinator explains that the SED waiver care coordinator is now the UnitedHealthcare care coordinator assigned to Henry, collaborating with the High Plains TCM to coordinate Henry's services and supports. Later that afternoon, the care coordinator formally introduces Shauna, by telephone, to Henry's SED waiver care coordinator, and both parties exchange contact numbers.

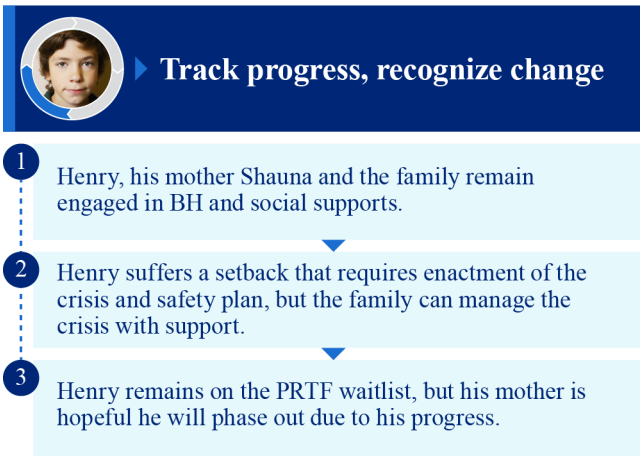
Henry's SED waiver care coordinator and the TCM check availability and schedule a visit in Henry's home to update his HRA and needs assessment. During the assessment, Shauna reports that Henry has been calm and agreeable since returning home. She reports that Henry is pleased that the CGM allows him to avoid getting his finger pricked, and he has been adherent with treatment. She adds that the Lexapro that was initiated at Camber appears to be helping. Lastly, she advises that she and the family have met the Family Preservation therapist. She said the therapist quickly developed rapport with family members and that the children were responding well to her.

At the end of this in-home meeting, the TCM and SED waiver care coordinator asked Shauna about availability to schedule a wraparound facilitation meeting at High Plains to complete Henry's person-centered service plan (PCSP). Shauna is also asked who she wants to invite to the meeting. Shauna states that in addition to High Plains staff, she is interested in inviting the family's Family Preservation therapist, DSNWK and the counselor from Henry's school. The wraparound facilitation meeting takes place at High Plains as scheduled, and the following services and supports become a part of Henry's plan of service:

- **Community psychiatric support and treatment (CPST):** Provides support and solution-focused interventions to help Henry and his family achieve the goals outlined on their PCSP.
- **Individual psychosocial rehabilitation services:** Provides education and coping skills for managing BH conditions.
- **Attendant care:** Provides one-on-one direct supervision.
- **Parent support services:** Provides consultation and support to parents of children with BH needs by those who have parented a child with BH needs.
- **Medication management:** Helps Henry manage his aggressive impulses. Henry was discharged from Camber with a 30-day supply of Lexapro, and Shauna decided to use Genoa Healthcare for ongoing pharmacy services.
- **Family therapy:** Supports to improve the interaction between family members and to acknowledge and heal from past trauma. Family therapy includes sessions without Henry, or the other children present to allow Shauna an opportunity to process her frustrations and fears and learn skills in managing her own emotions when interacting with her children.
- **Respite care:** High Plains has identified a family who is a good fit for Henry. High Plains arranges for Shauna to meet with the family, get to know them and to learn from Shauna about Henry's interests, personality and individual needs before respite services start.
- **Diabetes management:** Shauna reports good success with using the CGM. The SED waiver care coordinator directs Shauna to some information on pediatric meal preparation ideas.
- **School and individualized education plan (IEP) collaboration:** During the wraparound meeting, Henry's school provided an update, explaining that Henry does well despite periodic challenging behaviors. The school shared that Henry enjoys completing puzzles and spending time listening to music at school, and that he can become easily overwhelmed with too much stimulus or loud noises. Those in attendance take the recommendation and suggest that, moving forward, Henry use noise-canceling headphones in public or at home to reduce noise stimulus. The care coordinator notes that the noise-canceling headphones, if determined to be medically necessary by her PCP or BH provider, can be ordered under KanBeHealthy. Additional suggestions from the school are incorporated into the home support plans (e.g., using puzzles for self-soothing and obtaining an educational advocate through Families Together to maintain his IEP and support).

Before the PCSP meeting ends, DSNWK schedules a future date and time to come to Shauna's home and complete Henry's BASIS as a first step to getting him qualified for the IDD waiver. The TCM and SED waiver care coordinator thank everyone for their participation and express appreciation to Shauna for being open to suggestions and interventions. The TCM and the SED waiver care coordinator notify Shauna that, due to Henry's complex needs, they are contacting her at least monthly by telephone and conducting an in-person visit in the home at least once every other month, or more frequently as needed.

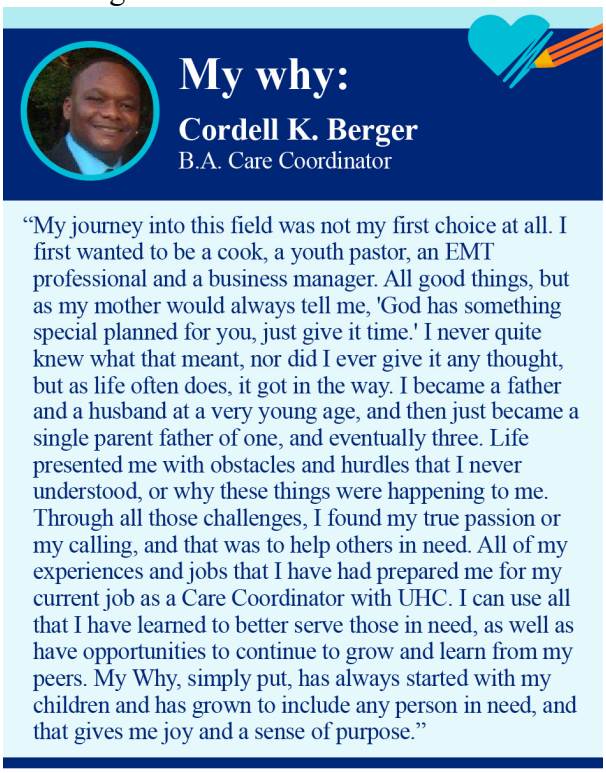
Track Progress, Recognize Change



For three weeks, the family experiences no significant needs after Henry's return home. Henry and his family continue to work with High Plains and participate in family therapy, which is beneficial for mom and Henry's siblings, addressing feelings of anxiety and fear while teaching them as a family how to manage disruptions or conflicts. Henry continues to actively participate with Family Preservation Services and adheres to his medication management regimen. Through her work with the High Plains therapist, Shauna has learned skills to manage Henry's behaviors and has gained increased confidence in her abilities to respond to conflict more effectively. During a regular check-in with the TCM and SED waiver care coordinator, she expresses appreciation for the ongoing relationship established with her parent support worker.

However, one day, Henry becomes upset after returning from a family outing in the park. He was yelling and became physically aggressive to himself and his mother, banging his head on the bedroom wall while pushing and swinging his arms about at Shauna as she tried desperately to calm him. Immediately, Shauna implemented her safety plan — she secluded Henry's younger siblings in a bedroom for their safety. She tried other approaches she learned, like speaking to Henry in a calm manner, offering him his noise-canceling headphones and even offering to play soft music for him. Despite her efforts, it became necessary to call the TFI Family Preservation Services therapist, who talked Shauna through de-escalating the situation and came to the home to make sure the crisis had been resolved.

The following day, Shauna, the High Plains crisis team, the Family Preservation therapist, the TCM, the SED waiver care coordinator and Shauna's parent support worker meet to debrief regarding the recent incident. Through the debriefing process, triggers to the incident were identified and adjustments were made to Henry's behavioral support and crisis plans. Shauna was pleased that another hospitalization was avoided. Through participation in family therapy and parent support, and with the aid of the DCF Family Preservation Services, Shauna has effectively learned how to implement a plan for managing Henry's behaviors and has strengthened her skills in de-escalating him when he starts to become upset. She reports that she is calmer and more confident in her approach to Henry, and he has responded favorably in return.



Due to Henry's complex needs, Henry's TCM and SED waiver care coordinator continue to check in with Shauna at least monthly and have face-to-face visits at the home with her every other month to review Henry's progress. A few months later, during a check-in, we learn that DSNWK recently completed Henry's BASIS, and Henry is on the IDD waiver waitlist. Henry is still on the PRTF waitlist, and Shauna wants to keep the PRTF admission option open but is now hopeful that PRTF is not needed due to Henry's progress.

Case Scenarios

34. Alice is a three (3)-year-old, white, female KanCare Member who lives in Holcomb and was referred by her pediatrician to a developmental pediatrician for further assessment. Alice is an only child. She started using words at 16 months of age, but her use of language has regressed. She communicates primarily using hand and body gestures.

In order to provide an opportunity for social engagement, Alice's parents enrolled Alice in day care. Alice attends day care three (3) days out of the week for four (4) hours per day. Contrary to Alice's parents' intentions, daycare staff report Alice isolates from and is unable to effectively communicate with other children and staff. Staff also report Alice engaged in head banging and hand flapping when they tried to engage her in activities.

Alice was assessed by the developmental pediatrician as being at risk for autism. The developmental pediatrician recommends Applied Behavior Analysis (ABA) therapy for Alice, specifically, early intensive behavioral intervention. The developmental pediatrician's office has contacted the bidder's Provider services line to assist with locating a Provider because the coordinator was unable to find an ABA therapist within a reasonable distance from the Member and her family.

Describe the process the bidder will follow to respond to the Provider's call and assist the Member.

Through UnitedHealthcare's experience caring for over 5,475 Kansas Members with autism, we have learned that an autism diagnosis affects the Member's whole family. A compounding challenge is a shortage of qualified applied behavioral analysis Providers. In 2022, we undertook a grassroots approach of following Members to recruit and invite their selected Providers to join our Provider network. We host biweekly meetings with identified ABA Providers who share new services, innovative approaches to evidence-based practice and industry updates. Through this collaboration, we **added 50 ABA Providers, growing our ABA Provider network by 127% in three years**.

Caregivers of children with special health care needs are two times more likely to use mental health services, and approximately one-third stop working outside the home to care for the child.[6] Our Family Support Program (FSP) team has the expert support of our ABA team, which comprises a dedicated Doctor of Psychology (PsyD) and Board-Certified Behavior Analyst – Doctoral (BCBA-D) led master's-level staff with extensive experience with autism spectrum disorder, ABA and early intensive behavioral intervention. The team's capabilities

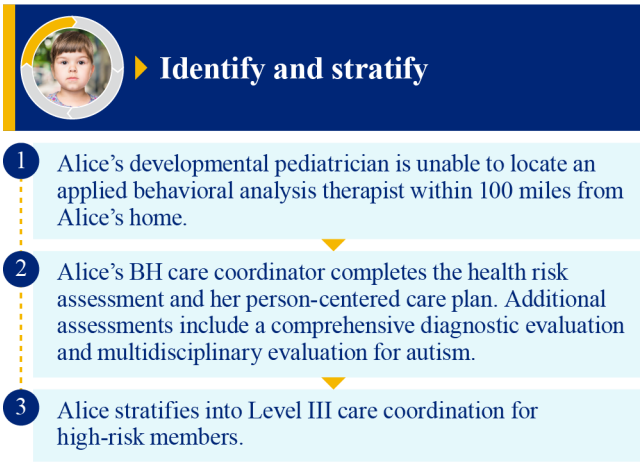
[6] Saunders BS, Tilford JM, Fussell JJ, et al. Financial and employment impact of intellectual disability on families of children with autism. *Families, Systems & Health*. 2015;33(1):36-45.

include providing tailored education, support and referrals to empower caregivers to make educated and confident decisions in improving health outcomes for their children like Alice.

Alice has been a UnitedHealthcare Member since birth. Her father, Keith, works as an auto detailer at a car dealership and her mother, Celeste, works part time as a housekeeper at a nearby hotel. Alice's very early development followed a normal course until about a year ago when her parents started noticing gradual changes in her communication and behavior.

Identify and Stratify

When the developmental pediatrician's office coordinator shares with our provider advocate, they were unable to locate an ABA Provider within 100 miles of Holcomb, the provider advocate realizes there must be an error in our online *Provider Directory* and confirms network ABA Provider capacity within time and distance standards for Alice. The provider advocate confirms the best contact information for the family and assures the pediatrician's office that a care coordinator will contact the family to assist. The provider advocate then reaches out to the care coordination manager and requests that a care coordinator contact the family for assistance in choosing an ABA Provider. The provider advocate also contacts the manager who oversees the online *Provider Directory* to alert them to correct the issue.



Our behavioral health (BH) care coordinator reaches out to Celeste by phone, explains their role and that they learned about Alice from her developmental pediatrician's office. The BH care coordinator asks Celeste to share a little about Alice and learns that Alice is an only child, loves toy cars and used to use more words but over the past year has become quieter. She is anxious about what the developmental pediatrician told her and wants to find a Provider to help her daughter as soon as possible. The BH care coordinator acknowledges Celeste's concerns and explains the need to complete the Kansas Pediatric Health Screening Tool (HST) as a first step to getting Alice the help she needs. Celeste voices understanding, and she and the BH care coordinator agree on a time and date when the family is off from work for an in-home assessment. Before disconnecting the call, the BH care coordinator asks if there are any emergent safety needs or lack of access to housing, food, water or electricity. Celeste denies immediate needs and thanks the BH care coordinator for agreeing to meet her at home the next day.

The BH care coordinator arrives at the home at the scheduled time. Keith has taken time off from work to participate, and the BH care coordinator meets with Keith and Celeste while Alice naps. The parents' answers to the HST questions automatically triggers the need for an HRA. The BH care coordinator explains the process and gains their permission to complete the HRA. Alice is stratified into Level III risk and the family agrees to care coordination.

The BH care coordinator takes this time to learn about how the family is coping with Alice's behaviors and what resources they need most urgently. Celeste expresses her fears for Alice and states she lacks confidence in knowing what to do next. The BH care coordinator brings up the Autism Speaks website on their laptop to show Celeste this online resource that provides a

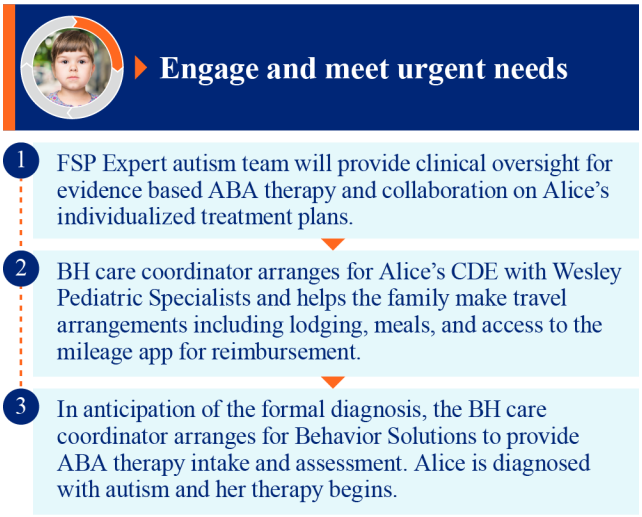
"Parent's Guide to Autism," along with various resources and support groups. The BH care coordinator asks about Alice's current health. Using the population health dashboard in CommunityCare, the BH coordinator sees that Alices is up to date on her immunizations and has completed all required KanBeHealthy well-child visits and confirms the information with Celeste. The BH care coordinator assures Celeste that they will find the right care for Alice, as close to home as possible.

The BH care coordinator takes this time to educate Keith and Celeste about our FSP. They say they feel comforted knowing they will be working with a licensed BH advocate who has at least three years' experience working with children like Alice. The BH care coordinator further explains that the FSP serves individuals through age 17 with certain complex BH conditions, including autism. Celeste expresses how overwhelming it is navigating the health care system but says with the BH care coordinator and the FSP team guiding their steps, they believe their family will be able to make educated and confident decisions.

After the HRA, the BH care coordinator and Celeste work together to complete Alice's care plan, which outlines Alice's strengths, needs, goals, preferences and the services and supports Alice needs. The BH care coordinator explains that the care plan will be reviewed during every contact and kept updated to include all services and supports Alice receives. These services may include occupational and speech therapies, transportation, DME, educational programs, family support and respite services. Alice's mother signs releases of information to allow coordination with the pediatrician and developmental pediatrician's offices.

Engage and Meet Urgent Needs

To meet Alice's most urgent needs, the BH care coordinator will arrange for Alice's comprehensive diagnostic evaluation (CDE); locate a Provider who will come to Alice's home to deliver ABA services; and make sure Keith and Celeste are connected to supportive and educational services.



While the developmental pediatrician has determined Alice is at risk for autism, the CDE is required for a definitive diagnosis of autism and to establish medical necessity for the ABA therapy. The BH care coordinator reaches out to Alice's PCP for a referral for the CDE. The BH care coordinator describes options for completing the examination, which must be completed in person. Wesley Pediatric Specialists in Wichita, which is just under four hours from home, is the closest CDE Provider. The BH care coordinator explains that the CDE takes about three hours and is completed by a medical doctor (psychiatrist), doctoral-level psychologist or licensed master's-level psychologist. The testing includes a psychological evaluation, which will provide a comprehensive picture of Alice's level of functioning and several other assessment tools.

The family has a car and will drive to the appointment but says it is a long drive each way for Alice who becomes restless in the car. The BH care coordinator reassures the family that

UnitedHealthcare will provide overnight lodging for the night before the appointment and will provide gift cards for meals on the trip. The BH care coordinator explains transportation trip and mileage reimbursement options to Celeste and helps her to access and use TripCare for nonemergency medical transportation on her phone. TripCare eliminates the paper process and allows for quicker mileage reimbursement without a phone call. Celeste calls Wesley Pediatric Specialists and learns that the first available appointment is in four weeks. She schedules the appointment and calls the BH care coordinator to let them know the date and time. She says Keith will be taking time away from work, and she has requested to be scheduled off.

Recently, a new Provider, Behavior Solutions, LLC, joined our network and participated in one of our ABA Provider meetings. From the meeting, the BH care coordinator remembers Behavior Solutions and confirms they are in the network and have a BCBA-D who can complete Alice's intake appointment and assessment in the family's home.

Following the completion of the CDE, the family asks that the evaluation results be sent to Behavior Solutions. The BCBA at Behavior Solutions submits an assessment request through the provider portal at *UHCprovider.com*. Once approved, the BCBA in-home ABA services can start. The BH care coordinator works with Celeste to schedule the visit within two weeks and explains Early Intensive Behavioral Intervention (EIBI) as treatment, which is based on the ABA principles and is the standard of care to help reduce Alice's hand flapping, head banging and communication. It is used to help young children learn new skills and behaviors in the areas of communication, play, self-help and social, emotional and cognitive skills.

The BH care coordinator acknowledges how overwhelming this all must feel and asks about supports the family currently has in place. Celeste shares that her sister lives nearby but works and has a child of her own. She says she does babysit for Alice occasionally. She shares that Keith works full time, and their time together is often focused on Alice. She is concerned that they do not get to spend much time together as a couple. The BH care coordinator asks if Keith and Celeste are interested in any support groups, and Celeste is receptive. The BH care coordinator adds family support needs to the person-centered care plan goals for continued research and coordination for the family. The BH care coordinator connects the family to the following resources:

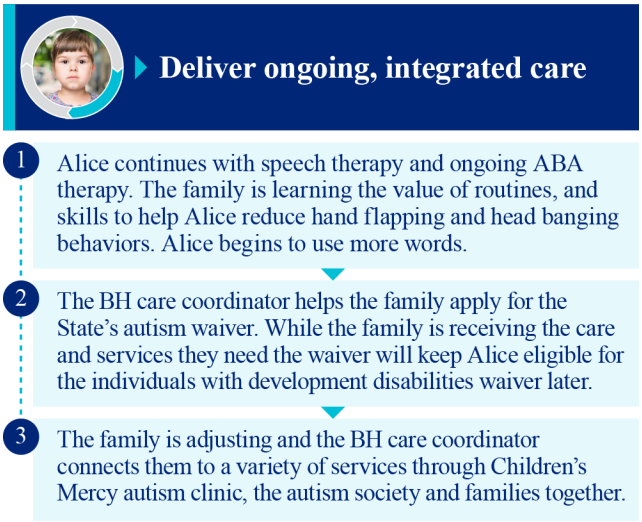
- **Russell Child Development Center (RCDC):** RCDC is a community-based, not-for-profit organization for early childhood programs. The BH care coordinator provides Celeste with information about how to access these services at RCDC:
  - **Learn and Play:** A free, in-person parent-child activity time held at least twice per month with partnering schools, churches and health departments in 27 locations across 19 Southwest Kansas counties. Learn and Play supports cognitive, social/emotional, speech/language, fine motor skill and gross motor skill development with a focus on early literacy.
  - **Triple P Positive Parenting Program:** Offers clear and simple ideas to help manage problem behavior or prevent problems from developing. Sessions, seminars and in-home coaching are available.
  - **Family Support Services (FSS):** Connects the family virtually and in person to an FSS manager who has training in meeting the needs of children like Alice. They assist with transition and portability, including planning and arranging services to follow the individual as they move from one service setting to the next.

- **Kansas Children's Service League (KCSL) Head Start:** Offers comprehensive childcare and early childhood education for children ages 3 to 4. In addition to providing high-quality early childhood education, the Head Start program offers physical and BH care and nutritional services that care for the whole child and support the entire family.
- **USD 363 Holcomb Supports:** Knowing that working on goals sooner rather than later will give her the best chance to meet them, the BH care coordinator educates her parents on supports available through Alice's school district, USD 363 Holcomb. Alice's mother shares she is interested in all supports she can get. BH care coordinator explains the next step is to make a call to the school and request a Child Find Screening to see whether Alice should be referred for an initial evaluation and whether she needs special education services.
- **Certified Community Behavioral Health Center Crisis Line and 988:** The BH care coordinator shares with Alice's family the 24 hours a day, seven days a week crisis services available to them through their local Certified Community Behavioral Health Center (CCBHC) Compass Behavioral Health in Garden City. Compass offers crisis response 24 hours a day, seven days a week, to Members in their area of coverage. During daytime hours or after-hours, they can expect to speak with a mental health professional. During daytime, working hours, they can simply walk into the office to receive crisis services should the need arise.

Alice's BH care coordinator takes the time to explain that, while they are the primary point of contact, there is a team-based model in place to meet Alice's needs and preferences. The BH care coordinator relays to Keith and Celeste that there will be a team of experts, including doctors, nurses, pharmacists and CHWs working with them and Alice's pediatrician to make sure Alice has all the supports she needs to thrive. Keith and Celeste are grateful for the help and say it helps relieve some of the stress on the family.

Deliver Ongoing, Integrated Care

Once we know Alice and her family have their immediate needs met, we move on to addressing other priorities that include formalizing Alice's autism diagnosis so that the family can apply for waiver services; connecting Alice to outpatient supports such as speech language pathology; establishing a connection to Alice's school district for early special education evaluation and supports; and arranging long-term social and emotional supports for both Alice and her parents.



Alice's CDE evaluators recommended speech language pathology evaluation and treatment. The FSP recommends early educational intervention. Alice's BH care coordinator reviews network outpatient therapies in and near Holcomb and identifies age-appropriate educational programs for Alice.

Speech Language Pathology: Alice's pediatrician ordered a speech therapy consult to help Alice with expressive and pragmatic language challenges. Alice's BH care coordinator conducts a three-way call to schedule Alice's intake at Perfect Fit Foundation in Dodge City. Since Perfect

Fit is about an hour from Alice's home, the BH care coordinator reminds Celeste to use TripCare to be reimbursed for travel expenses.

Ongoing ABA Therapy: With monthly care coordination calls and in-person visits every other month, the BH care coordinator works with Alice's family to meet her needs. At each scheduled visit with Celeste, the BH care coordinator asks her how Alice's ABA therapy is going. Celeste reports ABA therapy is going well, and she and Keith are receiving parent support and training as part of their sessions. Alice has been receiving ABA services three days week at the daycare and the other two days at home. The BCBA meets with Keith and Celeste twice per month and is teaching them how to manage behaviors in the home and continue Alice's skill development. Her parents are learning skills to help manage routines. The BCBA attends sessions in the home one time per week with the frontline staff to help ensure appropriate progress and problem solve.

Alice's BH care coordinator schedules a home visit to help Alice's mother understand the services available under the autism waiver include family adjustment counseling, parent support and training and respite care. The family decides to apply for the autism waiver. The BH care coordinator helps them complete application for autism waiver services and submit it, along with supporting documentation, to the Kansas Department for Aging and Disabilities Services (KDADS). The BH care coordinator explains to the family that in the coming months, they will receive a letter from the state autism program manager informing them they are on the proposed recipient list. The BH care coordinator further explains that once Alice is at the top of the proposed recipient list, the family will receive a call from the state autism program manager. The program manager will confirm the family's wish for Alice to enroll in the waiver program. The program manager will then contact KVC Behavioral Healthcare (KVC) who will complete a functional assessment with the family. Once Alice is found to be eligible, the program manager will send a form (ES-3160) to the state for final processing. Once UnitedHealthcare receives notification of waiver eligibility, the BH care coordinator will contact Alice's family within three business days.

The BH care coordinator educates the family regarding autism waiver services being a four-year waiver. At the end of the fourth year, the family has the option to apply for **transition to the IDD waiver**. If the family chooses to request transition to IDD, the BH care coordinator will guide the family though the transition. The BH care coordinator explains that the Community Developmental Disability Organization (CDDO) is the single point of entry for an individual or family to obtain services through the IDD system in Kansas. The CDDO is responsible for determining whether Alice will qualify for services. The BH care coordinator offers to make a three-way call with the family to the CDDO. The family states they are comfortable making the call. The BH care coordinator explains that to place Alice on the waiting list for the IDD waiver program, they will need to call Southwest Developmental Services, which is the CDDO that serves Alice's community. The BH care coordinator provides the phone number.

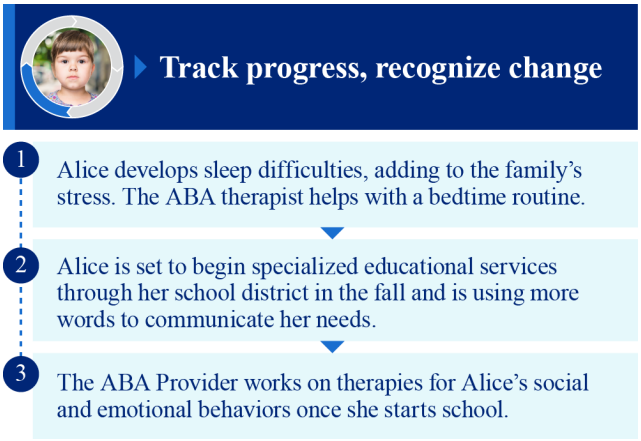
Now that all the assessments have been completed and Alice is receiving regular ABA and other services, the BH care coordinator visits with the family to see how things are going. Celeste says she would like to learn more about how other families cope with a child with autism. The BH care coordinator educates Celeste about these additional services:

- **Autism Society – The Heartland:** The BH care coordinator helps Keith and Celeste connect with the Autism society where they can learn more about autism and how to help Alice. They visit the lending library, attend Saturday seminars and follow the organization's

Facebook page. Most importantly, Keith and Celeste participate virtually in the family support groups where they network with other parents and gather information from guest speakers.

- **Families Together:** Celeste contacts Families Together in hopes of participating in their Parent-to-Parent program. The program matches parents who have experience raising a child with a disability with parents who need someone to listen, encourage and support them.

Track Progress, Recognize Change



Alice's BH care coordinator contacts Alice's parents by phone at least every 30 days and meets with them in person every other month. Alice's BH care coordinator monitors for ED, inpatient admission and discharge alerts through our care management platform, CommunityCare. At each point of contact, the BH care coordinator assesses for progress and needs and updates Alice's care plan and person-centered service plan.

On the most recent visit, Celeste appeared tired and anxious. The BH care coordinator asked her how she was doing, and Celeste started to cry. She says she is so tired because Alice will not sleep for more than an hour or two at a time. She says the sleepless nights are taking a toll on the family. She says Keith looks like a zombie most days and that she has had to miss work several times because of the stress. She and Keith argue about how best to address the problem. She says she is afraid of losing her job and is worried for her marriage.

The BH care coordinator reaches out to Behavior Solutions who will be seeing Alice later in the day and describes the situation. The therapist relays that they will bring some things to try to help Alice settle and sleep such as a sound machine and weighted blanket. The therapist will work with the family on Alice's bedtime routine.

The BH care coordinator shares with Celeste there is a free upcoming training through Russell Child Development Center on the topic of Creating Bedtime Routines. It is conducted online through Zoom. While the class says it is for caregivers of school-age children, the BH care coordinator suggests it may be useful information to know ahead of time as Alice gets closer to entering school. The BH care coordinator helps Celeste schedule an appointment with the developmental pediatrician to discuss other clinical approaches to Alice's sleep issue.

The developmental pediatrician educates Keith and Celeste that the first approach to Alice's sleep challenges is behavioral strategies like the ones already in place and that those approaches can take some time to be effective. The developmental pediatrician will revisit the possibility of adding medication for sleep if things do not improve by her next visit in three months.

After a few months, Celeste says the ABA and outpatient therapies are going well. Alice is sleeping better with a nighttime routine, is banging her head less than she used to and she has even added new words. In addition, with the implementation of behavior modification techniques, Celeste reports fewer stimming behaviors (hand flapping) and shares she is excited for Alice to begin special education services in the fall through USD 363. Alice's individualized

education plan (IEP) will include some therapies and work on social and emotional behaviors at school.

Alice will remain at Level III care coordination for the foreseeable future, and the BH care coordinator will continue a call and visit cadence of at least monthly calls and every other month in-person visits to support this family.

Helping a Member Like Alice: Isaac's Story

Situation: Isaac became a UnitedHealthcare Member via the Autism waiver when he was 5 years old. He had previously received a diagnosis of autism, and his parent was struggling to connect him to the correct supports. Isaac was using only gestures to communicate, was not toilet trained, demonstrated sensory issues that impacted feeding and had difficulty with social skills. Isaac's only supports were through his Individualized Education Plan (IEP) through his school district. All other needs were met through is mom, who shared she was overwhelmed with not knowing how or what supports to connect Isaac to.

Intervention: Upon engaging in the Autism waiver and with support of Isaac's care coordinator, Isaac's mom was referred to and connected with an ABA Provider, an occupational therapist, physical therapist and speech therapist while also obtaining necessary DME to help with toileting and diet needs. Isaac's mom began receiving parent support and training as part of ABA.

Outcome: Isaac is now learning to sign, uses visual aids and can use words such as "no" and "yes" to let his mom know what he needs. In addition, his receptive language skills are increasing, and his mom reports she feels he can understand more of what Isaac is saying. The outpatient occupational and physical therapies are leading toward gains in toileting, feeding and dressing routines. Isaac is also taking part in psychosocial groups through Playabilities working to increase social skills. He now will respond to playfulness of others, is increasing eye contact and engages in parallel play with peers. Mom reports Isaac "is doing great," and she feels his needs are met through their current supports.

Case Scenarios

35. Ernest is a senior executive with a hospital in a Rural area of the State. He reaches out to the bidder's Provider services call center seeking to find someone to speak to at an appropriate level in the MCO who will "take this situation seriously" and "has the authority to do something to try to fix this." Ernest explains that, as a Rural hospital, the ED provides a particularly important service for the community and surrounding area. The ED has, however, been struggling with the challenge of KanCare Members who present at the ED with significant psychiatric issues and who end up staying in the hospital's ED for extended periods because of a lack of available and suitable discharge options for them.

Ernest reminds your Provider services representative that the ED is small and that as a Rural area, the community heavily depends on being able to access ED services. He shares that providing "psychiatric boarding" in the ED for these Members is problematic for many reasons, including: the loss of available treatment space; the challenges presented to his staff, who are not trained to provide psychiatric care; Members' agitation and other disruptive behaviors that escalate as the ED stay lengthens; and the effect of the Members' behaviors on other ED patients.

Ernest states that he is concerned about the ED's ability to continue to ensure access to other patients in need of ED services, and that his staff, already under significant strain, may begin to leave hospital employment. Additionally, Ernest shares his concern that KanCare Members with psychiatric conditions do not have appropriate discharge options. Ernest says that while he recognizes this problem is not just limited to the bidder's MCO, your MCO is a contributor to the issue. Earnest wants to speak to the "right person" to understand what the bidder will do to address his concerns.

Describe how the bidder will route and handle the call from Ernest, and the bidder's approach to addressing the Provider's concerns.

Commitment to Provider Partners and Expedient Resolution of Concerns

At UnitedHealthcare, we value our partnerships with Providers and our commitments made to operational excellence. We take a "no wrong door" approach to Provider support, meaning, that regardless of which individual contacted, the Provider receives our commitment to a prompt response this is focused on promoting care access and high-quality service delivery. UnitedHealthcare staff, from provider services, call center, care management through the finance teams are trained to deliver on this promise. focused on promoting care access and high-quality service delivery. Through active listening and our deep community connections, we continue to put Members, Providers and the Kansas Community first. Our approach to addressing Provider inquiries includes the following strategies:

- Engage and listen so the Provider feels heard throughout interactions.
- Connect the Provider to the right person capable of addressing the specific inquiry or concern.
- Use root cause analysis discoveries and Provider interaction and lessons learned for process improvement opportunities.
- Provide a prompt response and collaborate on needs resolution.
- Provide education, support and other pathways that support or alleviate concern resolution.

Engage Ernest So He Feels Heard throughout the Interactions

We received Ernest's inquiry through the provider services center. The call is answered by a representative who, in listening to Ernest, understands that Ernest wants to be heard and does not want to waste time repeating his concerns to people without the authority to act. He is the chief executive officer of one of our rural network hospitals and is frustrated. The provider services center representative takes notes to memorialize the details of the conversation and when Ernest is finished sharing his concerns, restates the concerns back to Ernest to capture each point accurately in the documentation to support alignment on the concerns and resolution expectations:

- Lack of available discharge options for behavioral health (BH) patients enrolled in UnitedHealthcare KanCare
- Delayed discharges compromise ED access and staff stability
- Desire to speak to an authority figure who has authority to act on his concerns

We Provide Escalation that Allows Ernest to Work with a Capable Authority Figure

The provider services center representative tells Ernest there are escalation options available, i.e., he can choose to have provider advocate research his inquiry during the phone call or escalate this to an individual in a leadership role. Ernest chooses to escalate to a leader and chooses to collaborate with the provider relations director understanding that the initial contact occurs within at least 24 hours of his inquiry and during that contact, he receives a commitment on the time to resolution. The provider relations director, Ms. Carrie Kimes, is the right person to address Ernest's inquiry. Ms. Kimes knows Kansas, was born and raised in Topeka, and has 30 plus years of Medicaid experience, 11 of which are with UnitedHealthcare. She has served the KanCare population through UnitedHealthcare since September 2012 and possesses the necessary Kansas experience and influence to quickly move Ernest's concern to resolution, and is better positioned, due to its internal network of connections across UnitedHealthcare, to address the concerns comprehensively and promptly at hand.

Root Cause Analysis, Provider Interactions and Data, Drive Improvements

On receipt of Ernest's inquiry, our provider relations director immediately moves to the information gathering phase, looping in additional resources to assist with analyzing Ernest's needs and identifying the root causes — a fundamental process to getting to resolution. The provider relations director approaches the root cause analyst through the following activities:

- Engage with Ernest in fact finding, asking probing questions, make sure he is heard throughout the process, e.g., When do you engage the Community Mental Health Center/Certified Community Behavioral Health Clinic (CMHC/CCBHC), what is your ED's process to engage the CMHC/CCBHC to address a Member in crisis, e.g., at discharge or earlier and then do a mock walk-through of the intake process of an ED Member with BH conditions, reviewing how stakeholders interact throughout the process.
- Engage with the UnitedHealthcare leaders involved in MCO cross-collaboration activities to learn if Ernest's concerns have been raised at MCO committee meetings or the topic of past or present discussions, and if yes, learn more about the underlying discussions and resolution approaches under consideration.

- Query the hospital association partners and local CMHC/CCBHC contacts, similarly to the MCO approach above, to see if the ED boarding concern is widespread and if any other area hospitals are experiencing ED discharge challenges for psychiatric placements.
- Conduct an internal data analysis of Members with BH that are presenting at Ernest's ED to identify Members for proactive CMHC/CCBHC and other community-based BH service interventions, including participation in the UnitedHealthcare care coordination program.

Engage Ernest in a Fact-Finding Meeting for a Prompt and Comprehensive Resolution

The provider relations director conducts the fact-finding meeting with Ernest within one day and learns of their CMHC/CCBHC crises assessment engagement steps. They review the specific discharge challenges. Through the discussion, they learn that the ED staff is engaging the CMHC/CCBHC at the time of discharge vs. earlier in the process. In addition, Ernest adds that it is challenging to find psychiatric inpatient beds on discharge given that state hospital beds are usually at capacity. The provider relations director asks Ernest if there is anything else he wants to share and then asks if he is aware of the State Institution Alternative (SIA) program. Ernest is not aware of this program — a note is made to discuss this program in depth as it may provide needed ED boarding relief.

Engage MCO Cross-Collaboration Supports to Support Resolution Data Gathering

There is a vast amount of cross-collaboration with the State, the other KanCare MCOs, and the CMHCs/CCBHCs, addressing key challenges and capacity related concerns, including collaborative approaches to working together in making the Kansas BH system more efficient. The provider relations director knew from her experience with both hospitals and CMHC/CCBHCs that the ED psych-boarding had not been previously discussed but the industry had raised concerns over the timeliness of CMHC/CCBHC ED assessments, highlighting the importance of requesting the crisis assessments earlier in the ED visit.

Query Hospital Association and CMHC/CCBHC Contacts to Uncover Concerns

UnitedHealthcare attends quarterly meetings with the Kansas Hospital Association (KHA), attended by Kansas hospital executives. When the provider relations director inquired about Ernest's concerns, she remembered that one year earlier, at a KHA meeting, there was a general discussion concerning discharge needs but not one specifically related to BH or psychiatric placement challenges. The provider relations director calls the association contact and requests an email be sent to each committee member asking if they are aware of this scenario and wait for them to respond about their experiences with this situation. A couple of days passed, and the association contact reported back two hospitals reported having the same situation. After a deep dive, the association determined the concerns were isolated to rural hospitals, but not every rural hospital, two facilities — both are rural and frontier facilities that are supported by the same Kansas CMHC/CCBHC. The provider relations director makes a note to connect Ernest to the other two facilities, providing another collaborative resource to help him manage these challenges.

The provider relations director connects with the staff who facilitate the CMHC/CCBHC meetings. These meetings include the provider relations director, the provider services manager, and the dedicated CMHC/CCBHC provider advocate. These meetings aim to address industry needs as they arise and provide a forum for data and industry practices sharing between the

hospitals, UnitedHealthcare and the CMHC/CCBHCs. On review of past meeting notes and agenda items, the recurring need, most relevant to Ernest's inquiry is a CMHC/CCBHC workforce issue. The CMHC/CCBHC supporting Ernest's hospital has one FTE (full-time equivalent) allocated to the Qualified Mental Health Professionals (QMHP) role that supports two hospitals. To support completion of timely assessments, the ED must request an assessment as early in the ED visit as possible and well before the anticipated discharge to allow their only QMHP time to complete the necessary assessments and assist with discharge planning.

Multiple Collaborations with CMHC/CCBHCs

- Since May 2022, every Monday, the MCOs, the State, and the CMHC/CCBHCs hold a collaborative meeting to address specific issues that are common across our organizations and together.
- In addition, UnitedHealthcare attends one-on-one monthly meeting with the CMHCs/CCBHCs to review specific UnitedHealthcare concerns, meeting with the broader group and MCOs combined, on at least a quarterly basis.
- Our director of behavioral health meets twice monthly with the Association of Community Mental Health Centers of Kansas' Executive Board where each MCO is designated a specific meeting slot to present their individual concerns.
- UnitedHealthcare leaders convene at State KanCare meetings to support BH programs in addition to CMHC/CCBHC's.

The provider relations director is familiar with this need and contacts the CMHC/CCBHC supporting Ernest's hospital. Again, the contact explains they only have one FTE QMHP support per hospital due to funding. The provider relations director appreciates their challenge but given their local CMHC/CCBHC experience anticipates the response and offers to meet with the CMHC/CCBHC's crisis service billing team, suspecting that the funding shortfalls can be related to erroneous or underbilled crisis services and helps in identifying billing gaps that may provide the necessary funding that allows them to hire an additional resource. The CMHC/CCBHC contact appreciates the offer but adds that the concern might be related to challenges in finding qualified personnel. The provider relations director helps in finding qualified candidates and turns their attention to collaborating with the CMCH/CCBHC to help with hiring QMHP support.

Data Analysis to Proactively Identify Members for Interventions

The final piece of the root cause analysis rests with the internal data inquiries. Using claims and utilization data, we conducted a utilization analysis to identify Members who have been using Ernest's ED for BH support and crisis management. Proactively identifying these Members allows UnitedHealthcare to offer interventions that mitigate unnecessary ED use and pivot care, where appropriate, to the correct settings and Providers. Specifically, we run a one- to two-year claims history to identify Members who frequent the ED for psychiatric care or crisis management services. These Members are targeted for care coordination and opportunities to connect with a care Provider outside the ED and referrals for screening and align to the local CMHC/CCBHC for care and interventions. This targeted approach allows the provider services team to

Long-Term Relationships and Connections

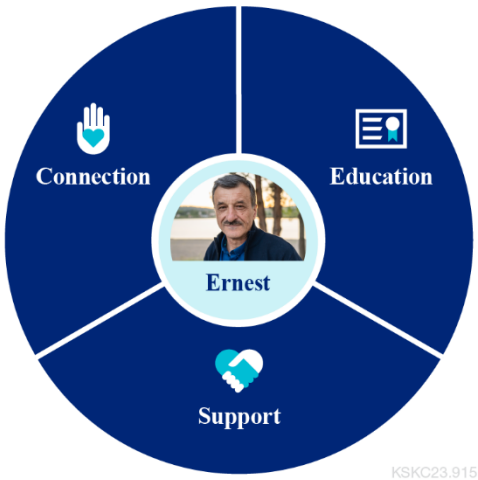
The provider services director has over 20 years' experience working with Kansas CMHCs/CCBHCs. Our provider services manager has over 10 years' experience. These long-term relationships with Providers enable UnitedHealthcare to lean into relationships, giving us the ability to quickly engage with the CMHC/CCBHC to resolve issues and quickly address those like Ernest's.

research Ernest's concerns in an informed manner and identify impactful solutions for Members through BH care coordination enrollment and CMHC/CCBHC referrals.

Promptly Share Findings and Offer Collaborative Resolutions

Through the collaborative efforts of our industry partners and CMCH/CCBHC Providers, coupled with our internal data analysis, our root cause analysis concludes, and we are ready to engage Ernest and offer tailored resolutions to address the specifics of each finding.

Figure 35-1. Wraparound Supports



The provider relations director telephones Ernest the following day, three days after his initial inquiry, to let him know that his inquiry has been researched and receive UnitedHealthcare support, education and connections to valuable resources to alleviate his concerns.

Educational Supports to Fill Process and Program Knowledge Gaps

Ernest's ED staff is unfamiliar with the SIA program and can use support understanding the Kansas regulations concerning CMHC/CCBHCs and their role in assessing BH patients who present at an ED, including supports to help the ED staff manage disruptive behaviors. These findings suggest that educational re-enforcements can help Ernest and his ED staff.

Protect the Emergency Department's Ability to Provide Access to Patients

UnitedHealthcare has established connections and good relationships with the local CMHC/CCBHCs and begins by sharing these contacts with Ernest, ensuring he and his team have a point of contact at the CMHC/CCBHC in his area and emphasizing the benefits of maintaining positive working relationships with the local CMHC/CCBHC QMHPs that we rely on for assessment, crisis interventions and psychiatric inpatient admissions.

Given that the only pathway for crisis stabilization services or an inpatient psychiatric admission is through a call placed to a QMHP of a CMHC/CCBHC facility, the discussion places emphasis on sharing CMHC/CCBHC referral and assessment process recommendations, including the following:

- How to engage with the CMHC/CCBHCs and their QMHP for support **before** planned discharges, i.e., timeliness of referral.
- Rules and regulations on CMHC/CCBHC screening requests to initiate a psychiatric admission or crisis intake.
- Observation policies are reviewed, highlighting for staff that they can bill for 72 hours of psychological observation while a Member is kept in their facility and their staff work with the local CMHC/CCBHC to find an I/P placement or crisis intervention.

The provider relations director goes on to explain that Crisis Intervention (CI) is a Medicaid benefit for UnitedHealthcare Members experiencing a psychiatric need. CI is provided by the local CMHCs/CCBHCs through their QMHP staff who come on-site to the ED to screen Members on request to determine the crisis level and the plan for crisis stabilization services.

The crisis management workflow is reviewed with Ernest, and steps are outlined on how to coordinate with the CMHC/CCBHC, including the need to connect before the planned discharge to help the QMHP to plan the ED visit before the discharge.

The provider relations director schedules a future meeting to arrange a personal introduction to the QMHP of the CMHC/CCBHC supporting Ernest's hospital and rounds off the CMHC/CCBHC discussion by providing the following information:

- **Crisis response.** Provided 24 hours a day, seven days a week, and includes mobile crisis support (for adults), emergency treatment and first response and, when appropriate, in-person interventions when discovering a Member is experiencing a crisis or other BH emergency.
- **Psychiatric referral.** Provide a referral to psychiatric and other community services, when appropriate.
- **Assessment.** Each Member who experiences BH crisis receives assessments to determine the need for inpatient, treatment, crisis services or other community treatment services, including assessments for targeted case management.
- **Emergency consultation and education.** These services are provided on request of law enforcement officers, other professionals or agencies to facilitate emergency services.
- **Follow-up.** Members seen or provided with emergency service for which they are not admitted, are assessed to determine the need for further services or support within 72 hours of crisis resolution.

Before addressing further resolution offerings, the provider relations director lets Ernest know that our UnitedHealthcare team works with the rural hospital to make sure the ED staff is aware of transportation options for our Members and how to connect with our nonemergency transportation (NEMT) vendor, emphasizing that UnitedHealthcare Members receive NEMT for covered services, and this includes trips to the CMHC/CCBHC following a BH facility discharge.

Address ED Psychiatric Extended Stay Concerns Related to Lack of Discharge Options

During the first call with Ernest, he shared that he was unfamiliar with the SIA program. Knowing this, the provider relations proceeded to share information on State programs that support Members with BH conditions and the available options for discharging Members with BH needs, including the new SIA program established by the Kansas Department for Aging and Disability Services (KDADS). The SIA program, we explained, allows area hospitals to designate open beds as State hospital psychiatric beds, effectively expanding State hospital psychiatric inpatient capacity and providing an alternative for psychiatric inpatient admissions when State facilities are full. The provider relations director added that this is a new program and shares additional SIA program details that allows participating hospitals to allocate unused beds to increase capacity for State psychiatric beds. In addition, Ernest received a copy of the SIA list highlighting the participating hospitals. The two agree to reconnect at the conclusion of the information gathering meetings with the MCOs and hospital associations to learn more about this program and review, in greater detail, the following:

- SIA admission and eligibility determination criteria, including age requirements, and how to engage the CMHC/CCBHC's QMHP for State Mental Health Hospital and SIA admissions screening process or other crisis assessments

- Identifying area hospitals that offer acute inpatient psych admissions and their transfer arrangement requirements

Help Emergency Department Staff Understand How to Manage Psychiatric Patients

UnitedHealthcare collaborates with Ernest and extends opportunities to engage his ED staff in training and programs to positively impact their perspective and BH management. The following supports are shared:

- **Skills system:** This is a two-day training tailored to clinicians and agencies to allow them to build competencies on treatment modalities, especially useful for individuals with intellectual and developmental disabilities experiencing co-occurring mental health conditions. Skills System provides emotion regulation strategies for the patient and their support systems and caregivers.
- **De-escalation training:** UnitedHealthcare offers training to the ED staff on how to defuse or de-escalate a situation with a Member in crisis.
- **Peer support and clinical health workers:** UnitedHealthcare connects Ernest with supports to augment his ED staff and further supports them in addressing BH patient needs.

Data Analysis to Identify Members for Care Coordination or CMHC/CCBHC Referral

The provider relations director adds that UnitedHealthcare has undertaken an internal data analysis to identify Members who benefit from BH care management and early intervention; this can alleviate adverse ED impacts from any Member seeking outpatient BH care in his ED. Based on our claims, Hotspotting tool analytics and our ED Diversion Dashboard, we can filter based on place of service, diagnosis or primary risk factor, and identify down to the facility level Members with potentially avoidable EDs, allowing us to proactively identify users of BH crisis services at his ED. These Members are now targeted for the case management program, with outreach communications scheduled within 24 to 48 hours.

The assigned care coordinator completes an HST or an HRA in addition to determining the Member's stratification. The stratification level provides the frequency and method of communication with the Member. Throughout these communication touchpoints, the care coordinator builds rapport, tracking the Member's progress and offering information on and connection with resources to improve Member functioning and prevent or reduce ED visits. Through care coordination, Members, through their regularly scheduled meeting cadence (based on risk stratification level), receive information on how to access crisis services (instead of the ED, where appropriate) and help them navigate the health care system. Care coordinators can access UnitedHealthcare's Crisis Support Tool to dispatch mobile crisis directly to a Member's location when needed. In addition, the data analysis supports the following activities:

- For identified Members, the data is used to initiate CMHC/CCBHC referrals, BH care coordination referrals or other proactive interventions or strategies to provide BH care and support to mitigate use of the ED for routine BH care.
- The analysis capabilities support collaborations with Ernest's ED team through ad hoc case utilization reviews that help identify Members who can benefit from proactive BH support and interventions (in addition to relying on claims and utilization data).

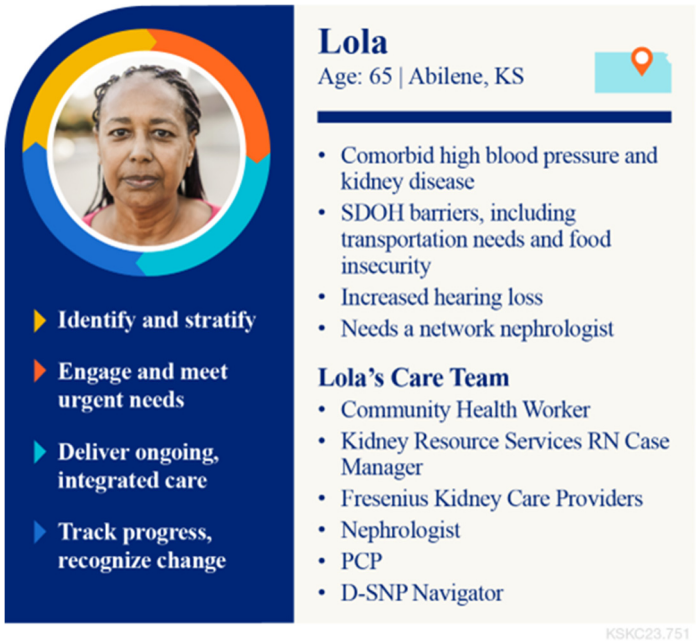
The provider relations director finishes the discussion by offering and then arranging interdisciplinary team (IDT) meetings, available on request. Interdisciplinary team and "case rounds" meetings are led by the UnitedHealthcare BH medical director, in partnership and at the

request of the Member's care team, as needed, to review specific Member challenges and BH topics of concern and collaborate on solutions and activities. Our IDT meeting attendance typically includes UnitedHealthcare leaders, including the chief medical officer and BH medical officer, Ernest, the chief attending physician of the ED and other team members who can participate and contribute to the review of cases and discuss improvements in processes. They schedule an IDT to review active cases and use that meeting to evaluate the effectiveness of his processes and outline recommendations to address gaps and improve strategies. The provider relations director and Ernest, including the ED staff, agree to meet weekly, to review systemic issues, reserving a slot to discuss Ernest's ED needs until stakeholders confirm the at-hand concerns are resolved.

Ernest expresses appreciation for the follow-up and actions taken to address his concerns adding that he feels he was heard throughout these discussions. The provider relations director continues checking in with Ernest, meeting at a regular cadence, until Ernest and his team indicate his needs have been met.

Case Scenarios

36. Lola is a black female KanCare Member who just turned sixty-five (65) years of age and enrolled in the bidder's dual eligible special needs plan (D-SNP). She lives by herself in Abilene. Lola has high blood pressure and kidney disease. She receives dialysis twice a week and requires Transportation to access care because she does not have a vehicle. Lola has a difficult time hearing, making it difficult for her to communicate on the phone, schedule appointments and Transportation, and understand treatment recommendations from her Providers. While Lola's Primary Care and dialysis Providers are in the bidder's D-SNP network, her Nephrologist is not. Describe the bidder's approach to meeting Lola's needs.



UnitedHealthcare's experience coordinating care for 13,609 D-SNP Members throughout Kansas informs our approach to provide a seamless experience across Medicare and Medicaid benefits for Members like Lola. **Since 2017, the first year of our D-SNP coverage in Kansas, UnitedHealthcare has consistently been rated 4.5 Stars or more through CMS Star ratings and is currently the only 5-Star D-SNP plan in Kansas.**

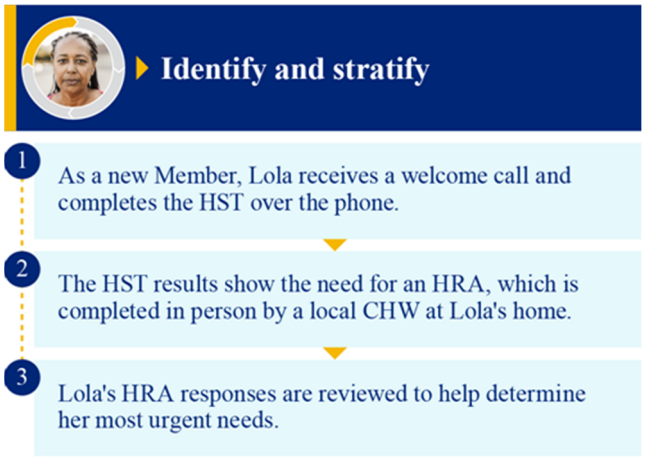
While Lola's needs are significant, she is not alone in what she is experiencing. In 2021, 71% of Kansas' Black Medicare population were diagnosed with hypertension, and 26% of this population suffers from chronic kidney disease, far exceeding national averages. Through early detection, early interventions and a structured approach to care, we can help Lola protect her current kidney function, manage her comorbidities and make sure she has the best quality of life possible. This strategy has driven improved outcomes for our Members. **Members enrolled in our care coordination programs experience a decrease in inpatient admissions per 1,000 of 20.7% and a decrease in ED visits per 1,000 of 10.8%** compared to pre-enrollment statistics.

These improvements are, in part, due to the work we do to remove barriers to care and help Members navigate a complex health care landscape. We are building programs, advancing innovations and improving outcomes for our Members. It all begins with identifying complex cases, like Lola, through our integrated, whole-person care coordination model, which addresses their physical, behavioral, social and functional health needs in a culturally competent manner.

Identify and Stratify

When Lola enrolls with UnitedHealthcare's D-SNP, she receives a welcome letter and ID card in the mail and a welcome call from our Hospitality Assessment Reminder Center (HARC) team. During the welcome call, Lola lets the HARC team member know she has some difficulty hearing on the phone, but she is able to hear them when they speak slowly, clearly and at an appropriate volume. The

HARC team member expresses understanding and guides Lola through the Health Screening Tool (HST) and explains the benefits Lola will receive as a UnitedHealthcare D-SNP Member, including:



- UCard, which is a combined health food, over-the-counter (OTC) items and utilities card that includes her D-SNP and Medicaid ID information
- Nonemergent transportation services for medical appointments and trips to places such as the grocery store
- Personal emergency response system through LifeLine to detect falls and other accidents
- A $2,500 hearing aid, $400 eyewear and $4,000 annual dental allowances

The HARC team member mentions to Lola that, based on the results of the HST, she would benefit from completing the HRA so we can gain a deeper understanding of her health care needs, assess her care coordination risk level and provide support to her in managing her whole-person health needs. Lola is warm transferred to a Community Health Worker (CHW) who is located near Abilene and trained on the full array of benefits available to Lola to schedule time to complete an in-person HRA. Lola agrees to a home visit in two days and confirms her address. The CHW asks if there is anyone Lola would like to invite as part of her support system to the visit. Lola shares she does not wish any friends, family or caregivers to accompany her.

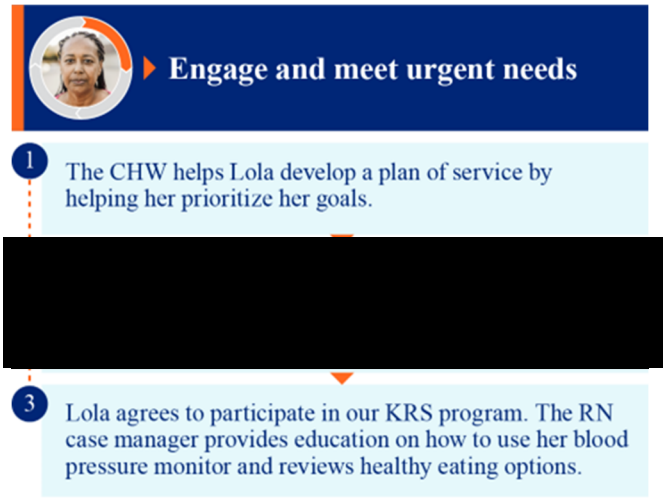
Before ending the call, the CHW asks if Lola has any emergent safety needs, housing insecurity or lack of access to food, water or electricity. Lola denies any immediate needs and confirms she knows how to call 911 if needed and is able to exit her home without assistance. Lola says she has her sister and her neighbor's contact information in case she needs assistance. The CHW confirms Lola's preferred method of communication — email and text — and updates Lola's communication preferences in her record in our care management platform, CommunityCare.

The CHW arrives at Lola's home at the scheduled time. Lola expresses how much she loves living in her own home and her desire to stay there as long as possible. The CHW explains the process to Lola and asks permission to proceed with completing the screenings, which she agrees to do. The CHW learns through the HRA that Lola is on a tight budget, and with limited funds, it is hard to afford healthy foods, so she relies on canned foods. Lola shares she suffers from some loneliness, as she only sees friends at her church on Sundays, which is very important to her.

The CHW discovers that Lola's nephrologist is out-of-network. In addition, dialysis is taking a toll on Lola and she is less energetic, tires easily and feels unsteady when getting dressed. She shares she uses a walker for long distances, but standing for long periods to cook and going grocery shopping is exhausting and her doctor recommended she incorporate low-impact exercise into her routine to build endurance. It is discovered that Lola's hearing has gotten worse over the last year, and she needs help scheduling an annual hearing exam. With some hesitancy, Lola shares she is not sure how many types of medications she takes each day, and that her doctor recently prescribed a new medication for her heart and instructed her to check her blood

pressure regularly at home. In addition, Lola made it known she no longer has her own transportation.

Engage and Meet Urgent Needs



The CHW helps Lola develop a plan of service based on Lola's answers to the HRA, taking care to not overwhelm Lola with too many interventions at once. Using motivational interviewing techniques, the CHW reviews each goal with Lola to prioritize her health care goals as high, medium and low. Together, they prioritize her goals of finding a network participating nephrologist, a plan for transportation, preventing further loss of kidney function by managing her blood pressure and finding ways to improve her diet. Once these immediate needs are addressed, Lola will explore her longer-term goals of working toward receiving a transplant if possible, increasing in her community engagement, managing her hearing loss, remaining living in her own home, addressing her loneliness and incorporating exercise into her routine.

The CHW explains to Lola that due to her living with hypertension and kidney disease, she qualifies for our Kidney Resource Services (KRS) program, which will provide her with a team of licensed renal care specialists, including a dedicated RN care manager, social worker, dieticians and board-certified nephrologist medical director, who work with Lola to provide one-on-one support and education to manage the unique challenges she faces. Lola is appreciative of the additional support. The CHW continues the visit with Lola, helping her address her Provider and transportation needs and schedules time with the KRS RN care manager for more support.

KRS Program is Driving Results

The Kansas KRS program for 2023 is performing higher than the United States Renal Data System (USRDS) national benchmark for 30-day readmission rates for Members with CKD at 20.6% (23.9% benchmark) and Members with ESRD at 29.7% (32% benchmark).

Because all nephrologists within a 45-mile radius of Lola's home participate in UnitedHealthcare's Medicaid and D-SNP programs (average distance is 21.8 miles), a non-network nephrologist is not something Lola would encounter with our plan. However, in the event of non-network Provider use, we would take the following actions, based on Lola's preferences:

- Attempt to contract with Lola's out-of-network nephrologist
- Help Lola identify a network nephrologist. The CHW uses the *Provider Directory* to generate a list of Providers taking new patients and works with Lola to choose one, verifying the nephrologist works with Lola's dialysis center, Fresenius Kidney Care in Salina
- Create a single case agreement with the non-network nephrologist to support continuity of care for Lola's active treatment plan

- Educate the D-SNP sales agent on the importance of verifying a Provider's participation with UnitedHealthcare before enrolling the Member

Lola's dialysis center is Fresenius Kidney Care located in Salina, which is approximately 24 miles from her home. She shares with her CHW that she is worried about making it to her dialysis appointments because she no longer has a vehicle. Her neighbor has offered to take her to her appointments for the next two weeks, but the neighbor will be unable to help after that period. The CHW explains to Lola she has nonemergency medical transportation (NEMT) benefits for rides to her doctor's appointments, dialysis and pharmacy at no cost through her Medicaid plan, and she can use these benefits to provide mileage reimbursement for the neighbor's trips as well. [redacted] She was excited to be able to schedule recurring rides to her dialysis appointments. While discussing transportation, Lola comments that the cost of her internet went up and is putting a strain on her budget. The CHW offers to help Lola get connected with low-cost internet access through the federal Affordable Connectivity Program.

The CHW concludes their first meeting with educating Lola on how to access her D-SNP navigator, with whom she can chat live via the *myuhc.com* Member portal for any assistance with understanding and use of benefits (both Medicaid and Medicare). The CHW acknowledges the amount of information. They reassure her that they will send a summary of what was discussed to Lola in an email and that the KRS RN has access to all the notes from their discussion through CommunityCare. They help Lola save their phone number and email address into her phone if she should need help in the future before they meet again. The CHW helps Lola schedule time with the RN to discuss how Lola can prevent further loss of kidney function, manage her blood pressure and find ways to improve her diet. Lola shares her appreciation for the CHW coming to visit her in her home and looks forward to the next meeting with the RN care manager in a week. The CHW lets Lola know the RN will text her the day before their next visit to confirm.

The RN contacts Lola the next week at the time Lola scheduled. Lola shares she feels overwhelmed with everything her Providers have advised she should be doing to manage her conditions, and at this point, she "feels like she is not doing anything right." Lola says her PCP often rushes through their visits, and they do not ask her questions about her challenges or if she understands the information being shared. She is uncertain about how to properly check her blood pressure at home, which was a treatment recommendation from her Provider. The RN explains that diabetes and high blood pressure are the two most common factors contributing to kidney disease, and genetics can play a part as well. The RN lets Lola know that it is not uncommon for people, especially Black Americans, to find out about their diagnosis until the disease is at a more advanced stage. This was due in part to outdated medical standards (retired in 2022), which adhered to a belief that Black Americans have more muscle mass than white Americans and, therefore, higher blood creatinine levels — a waste product of muscle activity that is filtered by the kidneys — were not concerning to doctors when they should have been.

The RN makes sure Lola is aware that the cost of a blood pressure cuff is covered by her benefits and that they can assist in obtaining one. The RN shares tips with Lola, such as making sure the bottom of the cuff is right above the bend of her elbow, relaxing for five minutes before taking her measurement and making sure her bladder is empty, as a full bladder can temporarily raise blood pressure. She also agrees to share these reminders via email so Lola has reference material on hand to support her success. The RN offers to meet with Lola via UnitedHealthcare's Care Support videoconferencing application once her blood pressure cuff arrives so the RN can walk Lola through how to properly check and track her blood pressure. Lola is appreciative of the help. The RN walks Lola through how to download the Care Support app on her phone, and they schedule time in one week, once the blood pressure cuff is delivered, to meet again.

When discussing Lola's goal to improve her diet, the RN asks open-ended questions such as "what have you done in the past to improve your diet?" and "tell me how your life will be different when you improve your diet" so Lola has the freedom to give as much detail and clarity as she desires. These details help the RN understand what has worked for Lola in the past, what has not worked and helps them understand her current motivation. The RN is empathetic and understanding, confirming that the recommended dietary changes can feel daunting and make people feel as if the foods they were used to eating were bad for them but they could not be expected to make changes if they were not aware of their condition. This made Lola feel better because she did not need to continue blaming herself. Lola finds grocery shopping to be more challenging now that she no longer drives, and it is more physically challenging than it used to be. Lola shares she has limited funds for healthy food choices and shares she consumes a lot of canned foods that are high in salt, negatively impacting her blood pressure.

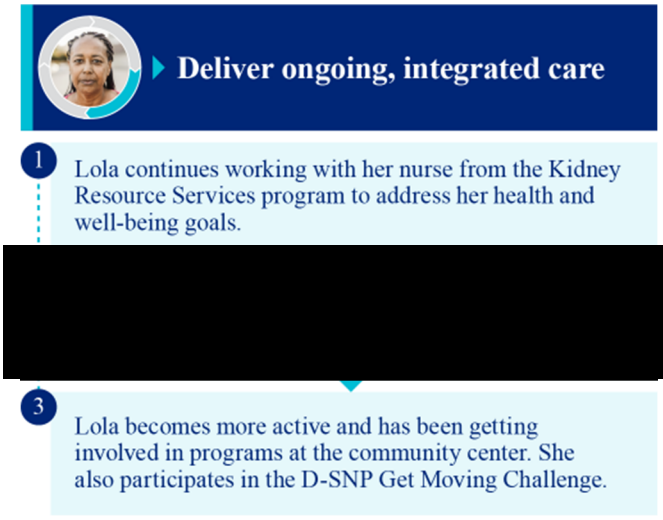
Lola's D-SNP benefits offer the ability for her to get set up with grocery delivery online in the comfort of their home with free shipping. The RN reminds Lola the UCard can be used to purchase healthy foods and OTC items up to $244 monthly. When discussing Lola's food benefits, Lola mentions that her dialysis center recommended she eat high-quality protein like poultry and eggs, but the price of food makes this change in diet difficult for her. The RN arranges home-delivered meals through a UnitedHealthcare VAB developed in accordance with the guidelines from the National Kidney Foundation and tailored to her cultural needs. The RN arranges for four weeks of the renal diet-specific meals to be delivered. If Lola finds the meals helpful, the RN will initiate the process for establishing two meals pers day of renal home-delivered meals. Lola is receiving Supplemental Nutrition Assistance Program (SNAP) benefits, so the RN provides education on SNAP's Double Up Food Bucks program, which allows Lola to use her SNAP electronic benefits transfer card to buy $5 worth of fruits and vegetables and get another $5 back to buy more fruits and vegetables of her choice, up to $25 per day.

The RN schedules time in two weeks for a check-in with Lola and reminds her she can contact her at any time. The RN updates Lola's plan of service and goals in CommunityCare, sharing the information with her PCP through UnitedHealthcare's Provider portal. The RN asks Lola how she would like her copy sent to her, and she asks for it to be emailed.

Deliver Ongoing, Integrated Care

Now that Lola's urgent needs have been addressed, the RN works with Lola on an ongoing basis to address medium- and long-term goals for her health and well-being. Over the course of their time working together, the RN helps Lola take small but meaningful steps toward achieving her goals of receiving a transplant if possible, managing her hearing loss, managing her medications,

addressing her loneliness, increasing in her community engagement, incorporating exercise into her routine and remaining living in her own home.



Transplant support: The renal care experts with our KRS program will educate, prepare and support Lola through her kidney disease journey, including, but not limited to:

- Educating on improved outcomes and quality of life when transplanted
- Providing information on Centers of Excellence transplant facilities, including the University of Kansas Health System Kidney Transplant Program
- Researching opportunities such as multi-listing and paired donor options
- Assisting Lola with obtaining a referral from her nephrologist and scheduling appointments with the transplant center
- Monitoring the status of evaluation testing completion and encouraging Lola to complete the required testing timely
- Continuing to support overall health needs to keep Lola in the best health as possible to receive a transplant

Hearing benefits: Because Lola has said her hearing has declined, the RN asks when Lola's last annual hearing exam occurred. Lola says it has been more than a year, and she would appreciate help finding a good hearing specialist. Together, Lola and the RN find a network Provider through Advanced Audiology in Abilene and schedule the exam [redacted] The RN makes sure Lola knows her benefits cover audiologist testing and evaluations, checkups and hearing aids, including her D-SNP benefit coverage of $2,500 for bilateral hearing aids. By confirming Lola's understanding of her benefits, the RN can help make sure Lola is making use of them to help improve her quality of life and overall health and well-being. The RN shares information with Lola about a resource called ClearCaptions, a device that provides captioning for her phone calls. The device displays the caller's words during phone conversations, specifically aimed at helping individuals whose hearing loss inhibits phone use. The RN assists Lola with the application process for the device so that she can better engage with Providers and other resources when they contact her by telephone.

Medication management: Lola shares she has some anxiety about picking up her medications from the pharmacy due to her transportation barriers. The RN suggests obtaining her medications through mail delivery to her home, which is offered by the Genoa Healthcare pharmacy in Salina, Kansas. Lola says that having them delivered would be very helpful. The RN shares that the Genoa Healthcare pharmacist can help her better understand her new heart medication and provide reminders when her refill will be delivered. Lola agrees, and they make the call together.

Mental health supports: Supporting Lola's mental health is an important component in her overall health. Knowing Lola shared during the HRA that she suffers from some loneliness, the RN asks about her social supports, special interests and hobbies. While Lola shares that she feels lonely at times, she does not consider it severe. The RN offers to show Lola a demo presentation

of Pyx Health, a mobile application, which has 24 hours a day, seven days a week chat function that screens for loneliness, depression and SDOH needs. The RN explains the application connects to a call center, which is staffed 24 hours a day, seven days a week, for inbound and outbound calls. Lola wants to get connected; the RN makes the referral and adds this as an intervention in her plan of service goal for addressing her loneliness. The RN lets Lola know they will review at their next visit if she feels this is a helpful intervention.

Community resources: The RN asks Lola if she has ever visited the Abilene Senior Center and participated in their activities. Lola mentions she is aware of the Senior Center but was not aware they offered activities. The RN pulls the site up on their laptop to explore what is offered. Together, they discover they offer blood pressure checks on the third and fourth Tuesday of each month, which is of interest to Lola. Lola notices they offer puzzles and dominoes, which she thinks would be an opportunity to get involved and make friends.

Online resources: The RN asks if Lola would like to take a look at an online community group offered by KDADS. The RN shares she saw a class there for heart healthy eating targeted toward dietary approaches to help with high blood pressure she might be interested in that is led by an instructor with a moderated chat for real-time questions and answers. Lola expresses interest, so the RN gives Lola a tour on their laptop. Lola finds this easy to use, and the RN helps Lola understand how to access it on her phone.

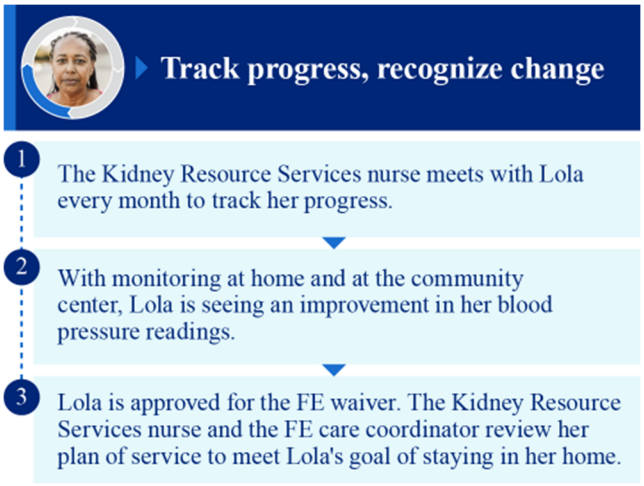
Peer mentoring: The RN mentions the National Kidney Foundation's peer mentoring program, where kidney patients are connected via phone with trained mentors. Mentors can share their experiences with dialysis and transplant and answer questions Lola may have. They will find the right person to talk with Lola, based on her personal situation.

Physical activity: The RN informs Lola that the Chism Trail Extension District has programs related to seniors living in Dickinson County. The RN shares a particular program with Lola, "Stay Strong, Stay Healthy," which is an evidence-based eight-week program for older adults for healthy muscle strength. The RN offers to get more specifics if Lola is interested, and she agrees that would help with her plan of service goals for incorporating exercise into her routine. The RN offers to look for community resources to help Lola get moving. The RN educates her on her D-SNP "Get Moving Challenge" benefit — with 30 minutes of activity each day for 10 days in the month, she can earn $10 each month. The RN shares with Lola she has another D-SNP benefit for a free Fitbit®, which can help her track her progress toward her plan of service goal for incorporating exercise into her routine.

Home- and community-based supports: Lola stresses the importance of remaining in her own home. The RN expresses understanding and shares with Lola the benefits associated with Frail Elderly (FE) waiver services if she were to be found eligible by the Aging and Disability Resource Centers (ADRC). The RN explains some of the benefits include personal care services to help her with cooking and grocery shopping. She can benefit from wellness monitoring, which allows regular nursing visits to monitor for changes in her blood pressure and overall health. It allows for home modifications if needs arise long term. Lola is relieved to hear she may be eligible for additional help at home. To help Lola with being assessed for eligibility for FE waiver services, the RN explains that they will begin the process by sending a form, called a 3160, to the North Central Flint ADRC. Lola is instructed to watch for a call from the ADRC, as they will do an eligibility assessment to determine her eligibility for the FE waiver, and there may be additional contact regarding financial eligibility. Lola expresses her understanding.

Track Progress and Recognize Change

The RN continues to check in with Lola every month to track progress toward her goals. When we follow up with Lola at her six-month check-in, the RN notes the following progress Lola has made toward her health and lifestyle goals:



- **Blood pressure management:** Lola shares she continues getting her pressures checked at the senior center and is checking it at home as well. She is seeing an improvement in her readings.
- **Addressing her loneliness and increase community engagement:** [redacted] and the transportation VAB. She uses this service to go to the senior center where she plays dominoes every Thursday with friends and shares the app has been easy to use.
- **Managing her hearing loss:** Lola has an easier time engaging by telephone using the ClearCaptions device and has gotten her new hearing aids with her $2,500 D-SNP benefit.
- **Improved diet:** The KRS dietician educated her on easy-to-prepare, heart healthy and kidney friendly meals and snacks. Lola reports the kidney home-delivered meals are very helpful, and she really loves the ease of ordering groceries online and having them delivered. She was even able to earn a $10 reward through the Connect with Others D-SNP benefit for making a healthy dish to share at a church event.

D-SNP Member Testimonial

"I brag on my insurance a lot because they do so much more than other insurance companies. I keep going back to my UCard. It helps a lot not having to stress so much about food, over the counter medicines or paying my gas bill."

– UnitedHealthcare D-SNP Member

- **Incorporating exercise into her routine:** Lola completed the D-SNP Get Moving Challenge and earned a $10 reward when she completed 30 minutes of exercise for 10 days in the month. She plans to continue and is excited to receive her $10 reward every month.
- **Care at home:** Lola's RN helped her set up UnitedHealthcare's Doctor Chat, our 24 hours a day, seven days a week telemedicine service, in case she had any urgent needs, was experiencing an exasperation of her condition or could not get in to see her Provider. Lola used it when she missed a dose of her blood pressure medication and wanted to know if she could take the dose late or if she should wait until her next scheduled dose.

Lola feels more comfortable managing her high blood pressure and kidney disease and is relieved she is on the transplant wait list. The RN is notified through our care management system that the state has approved Lola for FE Wavier Services and Lola will be transitioned to an FE waiver care coordinator. The RN and FE waiver care coordinator review Lola's plan of service and make a joint call to explain to Lola the next steps for the FE care coordinator to meet with Lola in her home to complete assessments and develop her person-centered plan of service. Lola welcomes the addition of FE waiver services to help her stay in her home as long as possible and is appreciative of the support provided by the UnitedHealthcare team.

Case Scenarios

37. Jason is a twenty-eight (28)-year-old, male, American Indian who is currently living with his family on the Potawatomi Indian Reservation, but intermittently moves off and on the Reservation. The bidder has just been notified of Jason's Enrollment in the bidder's MCO. Not only is Jason a new KanCare Member, he is also new to managed care.

Jason moved home after he was evicted from his apartment in Topeka for non-payment of rent. He has been unable to maintain ongoing employment due to inconsistent attendance.

Prior to Enrollment with the bidder, Jason was recently seen at a nearby non-participating Indian health care Provider (IHCP) where he was diagnosed with type 2 diabetes. Jason has a Hemoglobin A1C of 8.76 and has a history of binge drinking since age sixteen (16). He said he drinks when he is depressed and that his drinking and depression have created problems for his maintaining work and in his relationship with his family and friends. The nurse practitioner at the IHCP prescribed Metformin, recommended Jason consider participating in a special diabetes program offered through the Tribe, and provided Jason with a referral to a non-participating Provider for a Behavioral Health assessment and treatment. Jason has not followed up on either the recommendation or the referral.

Describe how the bidder will identify the needs of this KanCare Member, the bidder's approach to meeting the needs of the Member, and how the bidder will coordinate the Member's care.

Jason is a Member of the Potawatomi Nation. With over 38,000 Tribal Members, the Potawatomi are focused on protecting and nurturing their spiritual beliefs, historical values and the celebration of their unique traditions, language and sovereignty.[7] As an American Indian, Jason is eligible for Medicaid and is newly enrolled with UnitedHealthcare.

Jason's situation is not unlike many others of American Indian heritage. Specifically, American Indians are more likely to have diabetes than any other U.S. racial group,[8] and alcoholism and destructive drinking patterns are serious social concerns in many Native American communities.[9] UnitedHealthcare's experience providing integrated physical and behavioral health care services for over 1,200 Kansas American Indian and Alaska Native people informs our capabilities of working with Jason's Providers, BH experts, staff pharmacists, Tribal Community Health Representatives (CHRs) and others Jason identifies based on his evolving needs. Jason has visited the Prairie Band Health

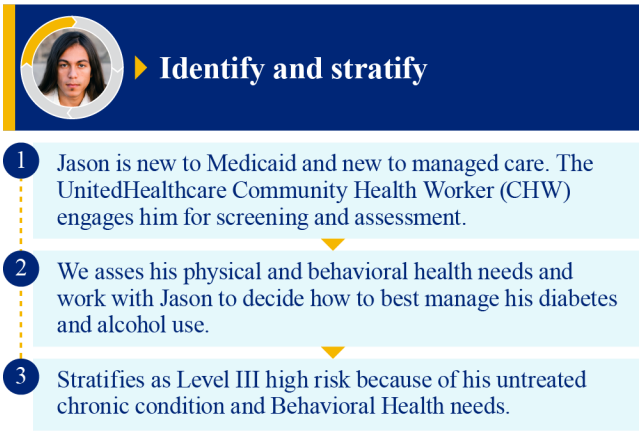
[7] Citizen Potawatomi Nation – People of the Place of the Fire.
[8] CDC.gov.
[9] (Beauvais, 1998; Hisnamick, 1992; May 1994; Wallace et al., 2003).

Center in the past. We strive to contract with all Kansas Indian health care Providers (IHCPs). Because this center is an IHCP, we treat the facility and its affiliated Providers as participating UnitedHealthcare Providers regardless of their nonparticipating status.

Our approach to integrated care coordination in Kansas has proven to be effective — 95.35% of our Members in care coordination are satisfied with their care coordinator and the percentage of Members with diabetes whose HbA1c was poorly controlled improved by 7.4% **from 2021 to 2022** — from **76.7% to 71.4%.**

Identify and Stratify

Jason's enrollment triggers a welcome letter and ID card mailing and a notification to our Hospitality Assessment Reminder Center (HARC) team for a welcome call in which the Kansas Health Screening Tool (HST) will be completed by phone. The HARC team's first two attempts to reach Jason by phone on different days and various times of day were unsuccessful. On the third attempt, on a different day, the HARC team member reaches Jason by phone.



During the welcome call, Jason seems suspicious and questions why he is receiving the phone call. The HARC team member explains that as a new Medicaid recipient enrolled in the KanCare program, he has been assigned to UnitedHealthcare as his health insurance company. The HARC team member describes the benefits Jason will receive as a UnitedHealthcare Member such as prescription drug coverage, access to primary and specialty care, including BH care, and help with food and housing. Using motivational interviewing skills, the HARC team member asks Jason if he would be willing to complete the HST so we can better understand his needs. Jason agrees to continue the conversation and screening. The HARC team member leverages their person-centered engagement strategy training to put Jason at ease during the discussion about very personal questions. Through the screening, we learn the following:

- Jason has been diagnosed with Type 2 diabetes and was prescribed metformin.
- Jason is nonadherent with his diabetes medication and never filled his prescription.
- Jason drinks more than six alcoholic beverages daily.
- Jason suffers from symptoms of depression.
- Jason is currently unemployed and, while he is housed with his mother, he desires a place of his own.

Jason auto-triggers for the Kansas HRA based on his responses to the HST. HARC connects Jason to a UnitedHealthcare Community Health Worker (CHW) via warm transfer. The CHW explains to Jason that the HRA must be completed in person. Through our engagement with the Kansas CHW Coalition, the UnitedHealthcare CHW knows there is a CHR in social services at the

Partnering with the American Heart Association to Improve American Indian Health

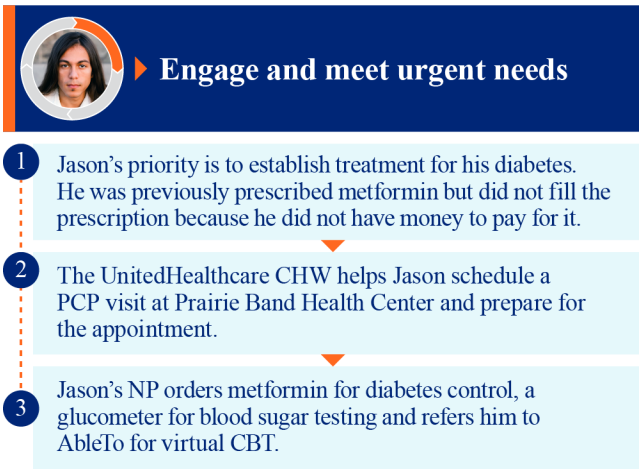
A UnitedHealthcare $275,000 grant supporting the American Heart Association's food as medicine initiative will deepen, expand and sustain partnerships with the four Kansas tribes. Through this grant, we will expand the annual Tribal Health Summit, support Indigenous communications, develop culturally sensitive partnerships and food systems, and build capacity for American Indian tribes in Kansas.

Prairie Band Health Center on the Potawatomi Reservation and asks Jason if he would like the CHR to attend his assessment. Jason says he has met the CHR before and agrees. Using a three-way call to the CHR, they schedule a convenient time for Jason to meet at the center the following week.

CHRs are essential to Tribal community health services because they come from and share Tribal cultural competencies and cultural healing remedies with their communities. The Prairie Band CHR knows there is stigma associated with alcohol use within the Potawatomi Tribe and reassures Jason that, no matter what he chooses or when, they will protect his privacy. The CHW completes the HRA confirming Jason qualifies for care coordination. They explain that care coordination involves focusing on his strengths and working together on a set of goals of his choosing. They explain that contact can be as often as he needs but will consist of at least monthly phone calls and in-person visits every other month. With reassurance from the CHR, Jason agrees to participate in UnitedHealthcare's care coordination.

Engage and Meet Urgent Needs

The CHW uses the HST and HRA to help identify Jason's needs to help him focus on the goals he wants to set. Jason says he has never thought about these kinds of things before. Using motivational interviewing, the CHW talks to Jason about the things that bother him most. He says he feels irritated all the time and just wants to feel better. The CHW explains that in addition to alcohol-related mood disturbances, unstable blood sugars from untreated diabetes can affect his mood.



He says he went to the Prairie Band Health Center, and the nurse practitioner (NP) there prescribed medication for his diabetes but he never got the prescription filled because he did not have any money to pay for it. The CHW explains to Jason that prescriptions are covered under his new insurance, so he will not need to worry about that. Based on the discussion, the CHW helps Jason develop his plan of service and document his immediate goals in our care coordination application, CommunityCare. His goals include re-establishing care with the NP at Prairie Band by attending an appointment within seven days and filling the prescriptions the NP gives him.

Jason agrees to an appointment at Prairie Band Health Center. The CHW offers to help with scheduling an appointment, but he says he will call tomorrow to get the appointment. He wants the CHW to hold him accountable for making the appointment and asks that they call him back tomorrow afternoon, and he will give the appointment date and time. The CHW calls Jason back the following afternoon as promised. Jason says he has an appointment for the following Monday.

To prepare for his upcoming visit, the CHW helps Jason make a list of things to discuss with the NP at the clinic. While Jason says he just wants treatment for his diabetes, the CHW introduces the subject of his BH needs, including his depression and alcohol use.

Jason says he often feels down and sometimes feels hopeless. He says he wants to make a better life for himself but does not really know where to start. He adds that he feels sad most of the

time, and drinking helps him feel better for a little while. He admits that feeling better from drinking does not last long. After a few drinks he says he becomes angry, sometimes yelling, slamming doors and throwing things. He knows his drinking scares his mother and that having a hangover most mornings was the reason he called off from work so much that he lost his job and apartment. He says he is hesitant to be honest about his alcohol use for fear of being judged and people knowing his business. His CHW encourages him to tell the NP about these things during his appointment, and shares that if he gets treatment for his depression, he may be in a better place to tackle hard things like his drinking and getting a job and a place of his own.

Jason is nervous before his primary care visit but keeps the appointment. His NP remembers him and engages Jason in a conversation about what has been going on. Jason admits to the NP that he never filled the prescription because he did not have the money to pay for it. He tells the NP about his feelings of sadness and that he drinks alcohol "occasionally." The NP actively listens and explains treatment options for his depression and diabetes. The NP gives Jason prescriptions for a glucometer and test strips, metformin for his diabetes and Prozac for his depression. Since there is no available therapist for cognitive behavioral therapy (CBT) at Prairie Band, the NP talks to Jason about his options for CBT, asking why he did not follow through with the referral after his last visit. Jason relays that he does not want anyone to see him going into a BH clinic. The NP mentions that AbleTo offers virtual care. Jason agrees to give it a try. The NP reminds Jason that drinking alcohol while taking metformin can reduce the effectiveness, leaving his blood sugars high, which can lead to other health complications. They explain how and how often to test his blood sugars and when to call the clinic. Jason agrees and visits the on-site pharmacy after his office visit to get his prescriptions.

AbleTo Provides Virtual Therapy for Jason

AbleTo provides virtual therapy programs with licensed Kansas therapists, leveraging the principles of CBT for people with mental health needs. Their program includes pathways for Members who have comorbid chronic medical conditions, such as diabetes, hypertension and chronic pain. AbleTo is committed to timely access, with an average of **six days to initial appointment**. Further, 48% of high-risk patients who engage in the program have experienced a reduction in hospital admissions.

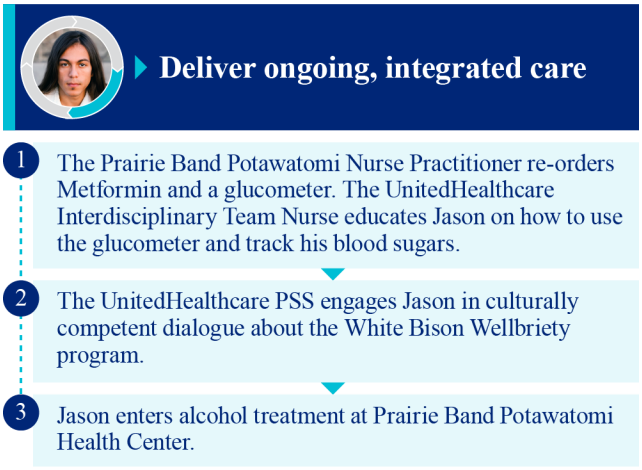
When Jason calls the CHW after his clinic visit, the CHW accesses Jason's record in our care coordination system, CommunityCare. Jason's record shows no ED or inpatient stays since their last check-in and that his prescriptions from the office visit have been filled. Jason says he has a "blood sugar meter" but is nervous to use it. He says that they showed him how to check his blood sugar and even had him "poke himself" to draw blood, but this meter looks different from the one at the clinic. The CHW helps Jason schedule a call with a UnitedHealthcare interdisciplinary team (IDT) nurse, who will walk him through how to use the meter, using Care Support video the next day. Care Support is a video conferencing application we use to facilitate virtual face-to-face visits with Members. The CHW walks Jason through downloading the Care Support app on his phone.

Jason's CHW introduces the idea of a certified peer support specialist (CPSS) to support Jason. They explain that a CPSS is someone who also suffered from depression and alcohol use disorder (AUD) and is in recovery. Jason says he will consider talking to someone later, just not now. He wants to focus on his diabetes and keep taking his medication for depression for now. The CHW sets a time in two weeks for a check-in with Jason but reminds him he can reach out any time. The CHW updates Jason's care plan and goals in CommunityCare, used by all UnitedHealthcare care coordination staff, which helps reduce the number of times Jason must tell his story.

Jason meets the UnitedHealthcare IDT nurse as scheduled for the video call the following day. The nurse reviews the testing parameters outlined by his doctor. Jason understands he is to call the clinic if his number is above 200 for three days or longer or drops below 75. Next, the IDT nurse talks Jason through a blood sugar check. Jason says he is now confident in his ability to check his blood sugar. Jason and the IDT nurse discuss his diet, including making sure he understands substantial amounts of sugar, including sugary drinks, and alcohol, can make things worse. Finally, the IDT nurse helps Jason sign up for the Diabetes Prevention Program class offered at Prairie Band Health and Wellness Center. Jason has no further questions and takes down the IDT nurse's number in case he thinks of a question later.

Deliver Ongoing, Integrated Care

Our care model is flexible and provides ongoing support for our Members like Jason whose care coordination needs may change over time. We individualize his experience, including tailoring follow-up outreach to a cadence that suits Jason's needs and focuses on what he feels is important, while not overwhelming him with too many things at once.



Our CHW reaches out to Jason for their scheduled call in two weeks. He reports that he is still taking the metformin and is thankful he did not have any of the common side effects such as nausea or diarrhea. He is checking his blood sugar levels in the morning "when he remembers." He has connected to the glucometer's phone app, which stores his readings and confirms there are readings in the app for the last four out of five days. He adds that he went to the clinic's on-site diabetes program that the IDT nurse recommended. Jason says it was helpful to see some familiar faces there, including his CHR, and he is learning about various foods and their effect on blood sugar. He says the numbers are not decreasing as fast as he had hoped. His CHW offers an educational resource, "Dining with Diabetes," which is a virtual class offered through K-State Extension and is a UnitedHealthcare VAB. The class is open to the public, but UnitedHealthcare will pay the tuition for Members who desire to participate. Jason says he may try that later.

Jason's CHW asks about his mood/depression. He says he is feeling better after starting the antidepressant and his AbleTo therapist is helping him work on ways he can repair his relationship with his family. His mom has been cooking some of the recipes recommended by the diabetes class. He says he has been helping her in the kitchen and trying to learn. He says cooking has been a helpful experience he shares with his mother and is hoping to continue spend positive time with her.

The CHW helps Jason to be more comfortable talking about his alcohol use and reminds him he does not have to decide to start treatment today. Jason says that he craves alcohol, and the thought of stopping is overwhelming. His CHW acknowledges Jason's feeling about stopping alcohol use and reminds him that his insurance benefits will cover treatment when he is ready. Frustrated, Jason says he is not ready to talk about his alcohol use and wants to end the call. The CHW asks if they can call Jason in one week to see how he is doing. Jason says, "okay."

When the CHW calls in one week, the call goes to voicemail. The CHW tries twice more without success. Finally, 10 days after their last call, the CHW reaches out to the CHR who reaches Jason in the late afternoon and with his permission adds the CHW to the call. Jason seems exceptionally low, and when the CHW asks him about his mood, Jason says he went on a binge, drinking heavily for five days in a row. He is angry and says he hates himself because he just cannot stop. The CHW again offers treatment but Jason refuses. The CHW again offers to connect Jason to peer support. This time Jason says, "okay" — that he would be open to hearing from someone who was able to stop. The CHW arranges for a UnitedHealthcare CPSS, who has completed cultural competency training, to meet with Jason at Starbucks at Jason's request in two days.

Jason's CPSS meets Jason for coffee as planned. They talk for a while, and the CPSS recounts their sobriety journey — including talking about times they were not successful and relapsed. The CPSS talks with Jason about how they found their motivation to begin treatment and, knowing Jason is American Indian, shares some information from White Bison. The CPSS relays the White Bison story of the sacred hoop of 100 Eagle Feathers and offers to lend Jason a copy of the book *The Red Road to Wellbriety in the Native American Way*, a collaborative effort of recovery stories designed to help Native American people enter and maintain their Red Road journey and life in Wellbriety. Jason says he saw a White Bison flyer at the clinic but did not pay much attention to it. He accepts the loan of the book. The CPSS agrees to talk with Jason any time and lets him know he can text if he is more comfortable communicating that way. The two engage in ongoing conversations by phone and text for the next several weeks.

Exploring Wellbriety

White Bison offers sobriety, recovery, addiction prevention and wellness learning resources as part of their Wellbriety Circle program to the Native American/Alaska Native community nationwide.

One month later, Jason attends his follow-up appointment. His NP is pleased that he is taking his metformin and checking blood sugar regularly. Jason completes his lab work, which shows his HbA1c is coming down. The NP keeps his medications at the current dosages.

Inspired by his CPSS and reading about Wellbriety, Jason tells the NP he is interested in learning more about the treatment they offer for alcohol use. The NP offers to walk Jason over to the substance use treatment office at the health clinic to get him started. Once they arrive, the staff welcome Jason and offer to see him for screening on the spot. Nervous, Jason agrees. Based on the screening, the therapist recommends Jason be enrolled in their day treatment program. They have an available appointment the next day. Jason says he wants to think about it but will call the next day.

The CPSS calls Jason to let him know they are proud of him and provides encouragement. They talk about the journey and agree Jason will take it one step, one day at a time. Jason calls the clinic the next day to start the day treatment program. In treatment, Jason learns about the 12-step program and attends two Alcoholics Anonymous meetings per week in addition to his day treatment. Through his CPSS, Jason learns about virtual Wellbriety Circle meetings hosted by White Bison. Jason feels this program will be a good fit for him in place of one of his in-person AA meetings. Jason says things are better with his mom but there is still tension. The CPSS suggests family therapy, which is available as part of his alcohol treatment program, for Jason and his mother to work on their relationship. The CPSS talks with Jason about scheduling an appointment around the same time as Jason's diabetes class so Jason can bring his mother to the

cooking class and visit the therapist at the same time. On a three-way call to the clinic, the CPSS arranges the appointment in two weeks.

Jason's CHW also calls him to review his follow-up PCP appointment. Jason says that his NP is pleased with his medication adherence and had no concerns with his lab work. He also reports that he did the AUD screening and decided he is going to start their day treatment program. He confirms that he has completed all the necessary paperwork. The CHW congratulates him on his decision and gives special positive reinforcement. The CHW ends the call on this positive note and reminds Jason that it is time for his in-person visit in two weeks. They schedule a time to meet at his home.

During Jason's home visit, the CHW sees that he and his mother live in one of the Prairie Band Potawatomi Nation senior housing one-bedroom rental units. While the home is neat and clean, it is small, and Jason feels like he is imposing on his mother. Jason has been sleeping on the couch since he moved in with his mother. The CHW tells him about our housing navigator who works with housing agencies and can assist him in accessing affordable housing. When Jason meets with the housing navigator, they share that Prairie Band added 27 new homes in 2019, which shifted some people from living in the apartment building, but there is still a waiting list. Jason mentions that he remembers seeing the construction and is interested. The housing navigator helps him get on the Prairie Band waiting list for a one-bedroom apartment.

Jason and his CHW discuss the possibility of Jason looking for a part-time job. He is in day treatment four days per week during the daytime hours but thinks he could work a few hours each week in the evening. He says that will help his efforts to stay sober by providing a distraction at the times he usually drank. The CHW tells him about similar support through our employment and education specialist (EES) who manages our education VAB and will support Jason with finding employment. The CHW tells Jason they will ask the EES to call him this week. Jason agrees. When Jason connects to the EES, he relays that he never graduated high school. He feels his lack of a diploma along with alcohol use were major barriers to his employment in the past. His EES tells him about the Prairie Band adult education program that provides student grants for Tribal Members. The program provides funding for GED preparation classes and the exam. The EES shares that his $200 per year UnitedHealthcare education VAB can help him pay for study guides and transportation to his GED preparation classes and exam.

Track Progress, Recognize Change

Jason has met the immediate, pressing goals of getting connected with Providers and treatment for his diabetes, depression and alcohol use. He understands his conditions and how to contact his Providers, if needed. His level of care coordination is reduced to Level II.

Using CommunityCare, the CHW monitors for things such as medication adherence, ED visits, inpatient hospitalizations, calls to the NurseLine, or any HEDIS® preventive care gaps. Two months after his last in-person visit, the CHW received a real-time alert in CommunityCare that Jason visited the ED and immediately called Jason to check in. He said he was clearing brush on his friend's property and cut his leg. He received stitches and a tetanus shot. He has an appointment at the clinic in a week to have the stitches removed.

Since our CHW has Jason on the call, they access the population health dashboard in CommunityCare and note he is due for his annual influenza vaccine. The CHW reminds him that

he can earn a $25 healthy rewards gift card for reaching his treatment goals. He is non-committal on getting the shot but will discuss it with his PCP when he goes for the follow-up appointment regarding his stitches.

The CHW also reviews Jason's plan of service and asks how other things are going. Jason reports that he is still in the alcohol day treatment program and that the EES helped him find a job working at Dollar General part time. Unlike his past employment, he says he has never called in sick or missed a scheduled shift.

Jason successfully completed his treatment program and has been sober for six months. He attends weekly support sessions, AA meetings and the Wellbriety circle virtual meetings. Jason's diabetes is under control with diet and medication. He sees his PCP every three months for lab work. He has obtained his GED, has moved to working the day shift at Dollar General and is getting more hours. He is still living with his mom, but says he is second on the waiting list for an apartment at Prairie Band. Currently, Jason no longer needs ongoing care coordination. UnitedHealthcare continues to monitor admission, discharge and transfer alerts in CommunityCare and will re-engage Jason should he have a significant change in condition and a need for re-engagement in care coordination.

Helping a Member Like Jason: Rodney's Story

Rodney is 60 years old and is in recovery from AUD. In addition to his AUD, Rodney is diagnosed with Type 2 diabetes, congestive heart failure with pacemaker, hypothyroidism, asthma, hepatitis C, schizophrenia and post-traumatic stress. In 2022, Rodney became homeless and was living with others in a homeless camp near Kansas City. After a night of heavy drinking, Rodney passed out next to his campfire. He was badly burned and hospitalized. When the time came for his discharge, all shelters were full, and he was released to homelessness. With poor hygiene, Rodney developed several infections and was seen in the ED. However, he was not adherent with treatment and signed himself out of the ED against medical advice. With the support of his sister and his UnitedHealthcare care coordinator and CHW, Rodney finally agreed to get help. He was admitted to the regional alcohol and drug assessment center where he received treatment for his alcohol use, BH and medical concerns. Rodney's CHW helped him complete screening for HCBS for housing, food and transportation needs. Today, Rodney maintains his sobriety and is living independently in the community.